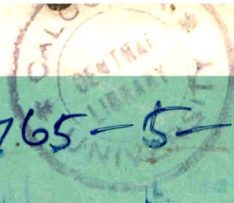


Volume 129: No. 5

November 1972

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THE AMERICAN JOURNAL OF PSYCHIATRY



This Month's Special Section
Group Therapy

5

Official Journal of the American Psychiatric Association



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- Witchcraft and psychiatry working side by side
- New legal developments with implications for psychiatrists and their patients
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- A challenge for humane and positive involvement with prisoners and the prison system

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in

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Applications are now being accepted for the new traineeship year beginning July 1, 1973 for psychiatrists who have completed three years of residency. The fellowship positions are available in an N.I.M.H. supported program providing basic preparation for psychiatric research. Emphasis is on acquiring proficiency in the fundamental principles of research strategy, methodology and techniques currently employed in laboratory and clinical studies in psychiatry. The traineeships stress active participation in research work under the supervision of faculty preceptors, supplemented by a curriculum of seminars and workshops. Appointments are full-time and extend one to two years.

and in

PSYCHOSOMATIC AND LIAISON PSYCHIATRY

Full- and half-time fellowships in psychosomatic and liaison psychiatry will be available beginning July 1, 1973 for psychiatrists who have completed 3 years of residency. The program supported by the N.I.M.H. offers experience in teaching and research, as well as in clinical work dealing with the psychological aspects of somatic illness. The fellows function as liaison psychiatrists to a variety of hospital- and community-based medical groups. Teaching exercises include clinical conferences, seminars and workshops, as well as supervision by senior faculty on special projects. Areas of study range from psychosomatic mechanisms to the functioning of the medical ward as a social system.

For details write (before January 15) to:

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Edward J. Sachar, M.D. (Psychosomatic and Liaison Program)
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CONTENTS: November 1972

Volume 129, Number 5

The Phases of Adult Life: A Study in Developmental Psychology	<i>Roger L. Gould</i>	521
Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children	<i>L.M. Greenberg, M.A. Deem, and S. McMahon</i>	532
The Effect of Third-Party Payment on the Practice of Psychotherapy	<i>Paul Chodoff</i>	540
Women Who Seek Therapeutic Abortion: A Comparison with Women Who Complete Their Pregnancies	<i>Charles V. Ford, Pietro Castelnuovo-Tedesco, and Kahlila D. Long</i>	546
The Jewishness of Jewish Young People: A Symposium	<i>Mortimer Ostow, Mortimer J. Blumenthal, Jacob A. Arlow, and Peter B. Neubauer</i>	553
On the Bicentenary of the Birth of Esquirol (1772-1840), the First Complete Psychiatrist	<i>George Mora</i>	562
Subcontracts for Community Development and Service		

Adolescents in Crisis: Evaluation of a Questionnaire *Alvin Yusin, Ruth Sinay, and Kazuo Nihira* 574

Continuing Education for Community Psychiatry *Louis F. Rittelmeyer, Jr., Robert G. Kvarnes, and Irving Schneider* 578

SPECIAL SECTION

Group Therapy

Peer Confrontation Groups: What, Why, and Whether *William W. Van Stone and Robert Gilbert* 583

The Psychodynamics of Quitting Smoking in a Group *John S. Tamerin* 589

Group Psychotherapy in the Soviet Union *Isidore Ziferstein* 595

Counter-Playing: A Group Therapy Technique *James M. Krainin* 600

The Effectiveness of Group Psychotherapy in a Correctional Institution *Charles C. Jew, T.L. Clanon, and Arthur L. Matlocks* 602

DEPARTMENTS

EDITOR'S NOTEBOOK

Group Psychotherapy in Perspective *Hyman Spothnitz* 606

BRIEF COMMUNICATIONS

Adolescent Maladjustment or Affective Disorder? *Johnnie L. Gallemore, Jr., and William P. Wilson* 608

Physician Use of Marijuana, Alcohol, and Tobacco *Marlin R. Lipp and Samuel G. Benson* 612

The Attitudes of Patients and Their Trainee Therapists Toward Participation in Psychiatric Board Examinations *Herbert H. Eveloff and Charles P. McCreary* 616

Acute Brain Syndrome Associated with Lithium Therapy *Peter L. Agulnik, Alberto DiMascio, and Patricia Moore* 621

Two-Way Television: Helping the Medical Center Reach Out *Cecil L. Willson and Anna Benschofer* 624

Exogenous Water Intoxication: A Case Report *Michael W. Devereaux and Ruth Cormick* 628

LETTERS TO THE EDITOR 631

Correction: Berns et al: "Research on Student Activism" (128:1503, 1972) 636

REVIEWS 637

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1. Berne E: Principles of Group Treatment. New York, Oxford University Press, 1966, p 26
2. Schildkraut JJ: Tranlycypromine: effects on norepinephrine metabolism in rat brain. *Amer J Psychiat* 126: 925-931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interactions between monoamine oxidase inhibitors and foodstuffs. *Brit J Psychiat* 113: 349-365, 1967

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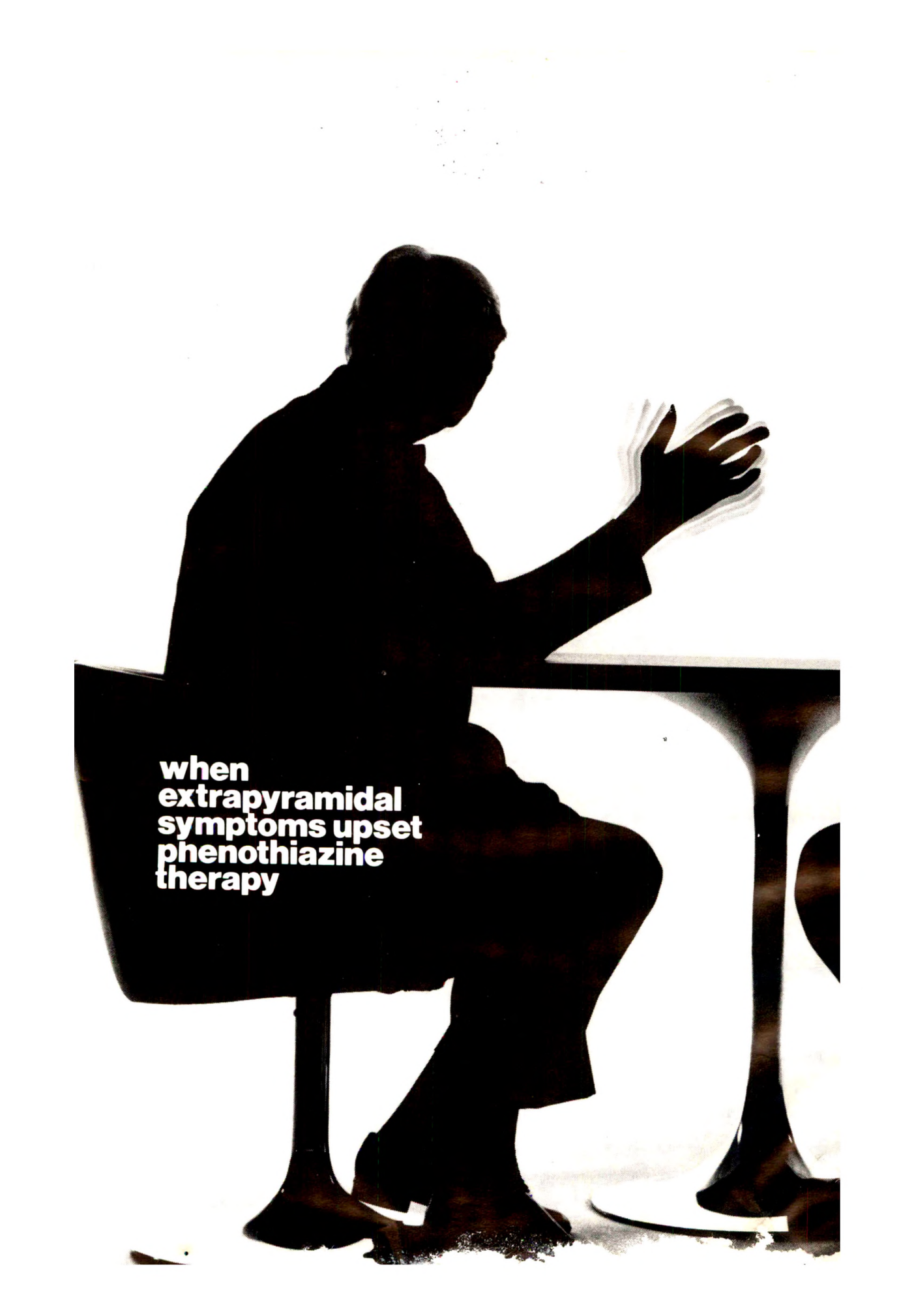
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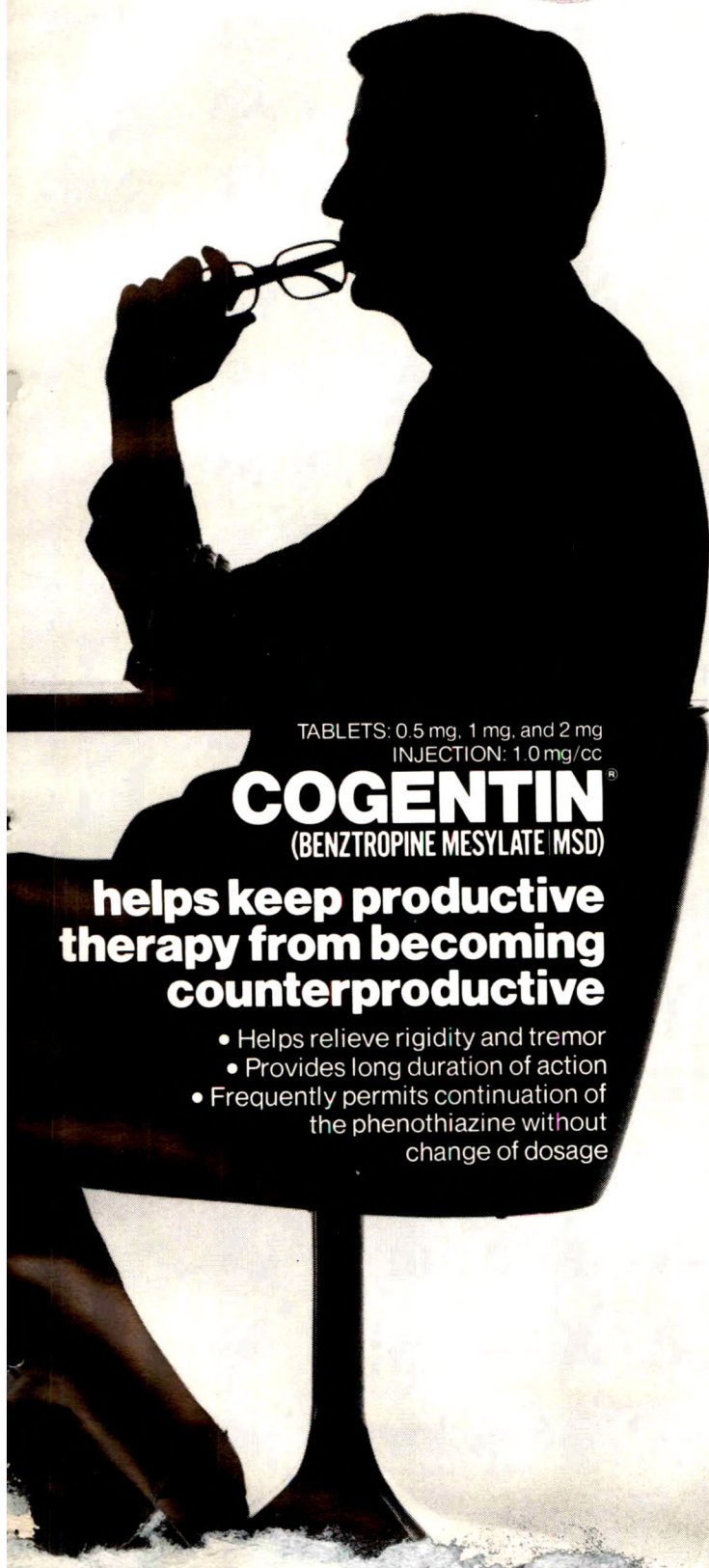
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Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

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Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Masking action on possible development of permanent extrapyramidal symptoms with prolonged phenothiazine therapy has not been investigated. Patients with a poor mental outlook are usually poor candidates for therapy.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. In drug-induced parkinsonism, closely observe patients for severe reactions, and temporarily discontinue COGENTIN (Benzotropine Mesylate, MSD) if they appear; do not extend therapy longer than necessary to counteract the extrapyramidal disorders; although the psychotropic drug frequently can be continued without change of dosage, a decrease might be indicated.

Adverse Reactions: Adverse reactions may be anticholinergic and/or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

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In a hospital study, psychiatric patients with insomnia problems slept through the night without need to repeat dosage

Subjective and objective reports in a double-blind study¹ demonstrated the clinical effectiveness of Dalmane (flurazepam HCl). Included were forty-nine insomniacs hospitalized for psychiatric reasons. One 30-mg capsule of Dalmane h.s. was significantly superior to a placebo in:

- markedly reducing sleep induction time and nocturnal awakenings
- helping insomniacs sleep for an average of 6.8 hours nightly.

In addition Dalmane was consistently effective on each of seven consecutive nights in which it was administered.

Relatively safe, as reported clinically

- No serious side effects were reported in this study.
- In general clinical use, morning "hang-over" has been relatively infrequent; dizziness, drowsiness, lightheadedness and the like, were the side effects noted most frequently, particularly in the elderly or debilitated.
- Human chronic tolerance studies, in which high doses were administered for prolonged periods of time, confirmed the relative safety of Dalmane (flurazepam HCl).

Dalmane (flurazepam HCl) can be used effectively for patients in acute or chronic medical situations requiring restful sleep.

References

1. Jacobson, A., et al.: *Psychophysiology* 7:345, 1970.
2. Kales, J., et al.: *Clin. Pharmacol. Ther.* 12:691, 1971.
3. Kales, A., et al.: *Arch. Gen. Psychiat.* 23:226, 1970.
4. Kales, A., and Kales, J.: *J.A.M.A.* 213:2229, 1970.
5. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970; and at 42nd Annual Scientific Meeting, Aerospace Med. Assoc., Houston, April 26-29, 1971.
6. Karacan, I., et al.: "The Sleep Laboratory in the Investigation of Sleep and Sleep Disturbances," Scientific Exhibit presented at Amer. Psychiat. Assoc., Washington, D.C., May 3-7, 1971.
7. Dement, W. C.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N. J.
8. Vogel, G. W.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N. J.



Sleep research laboratories proved effectiveness for patients with difficulty falling asleep, staying asleep or both

Electroencephalographic, electro-oculographic and electromyographic tracings²⁻⁸ proved that one 30-mg capsule of Dalmane usually:

- induced sleep within 17 minutes
- decreased nocturnal awakenings and the time awake after sleep onset
- provided 7 to 8 hours of sleep without need to repeat dosage during the night

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One 30-mg capsule h.s.—usual adult dosage.
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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

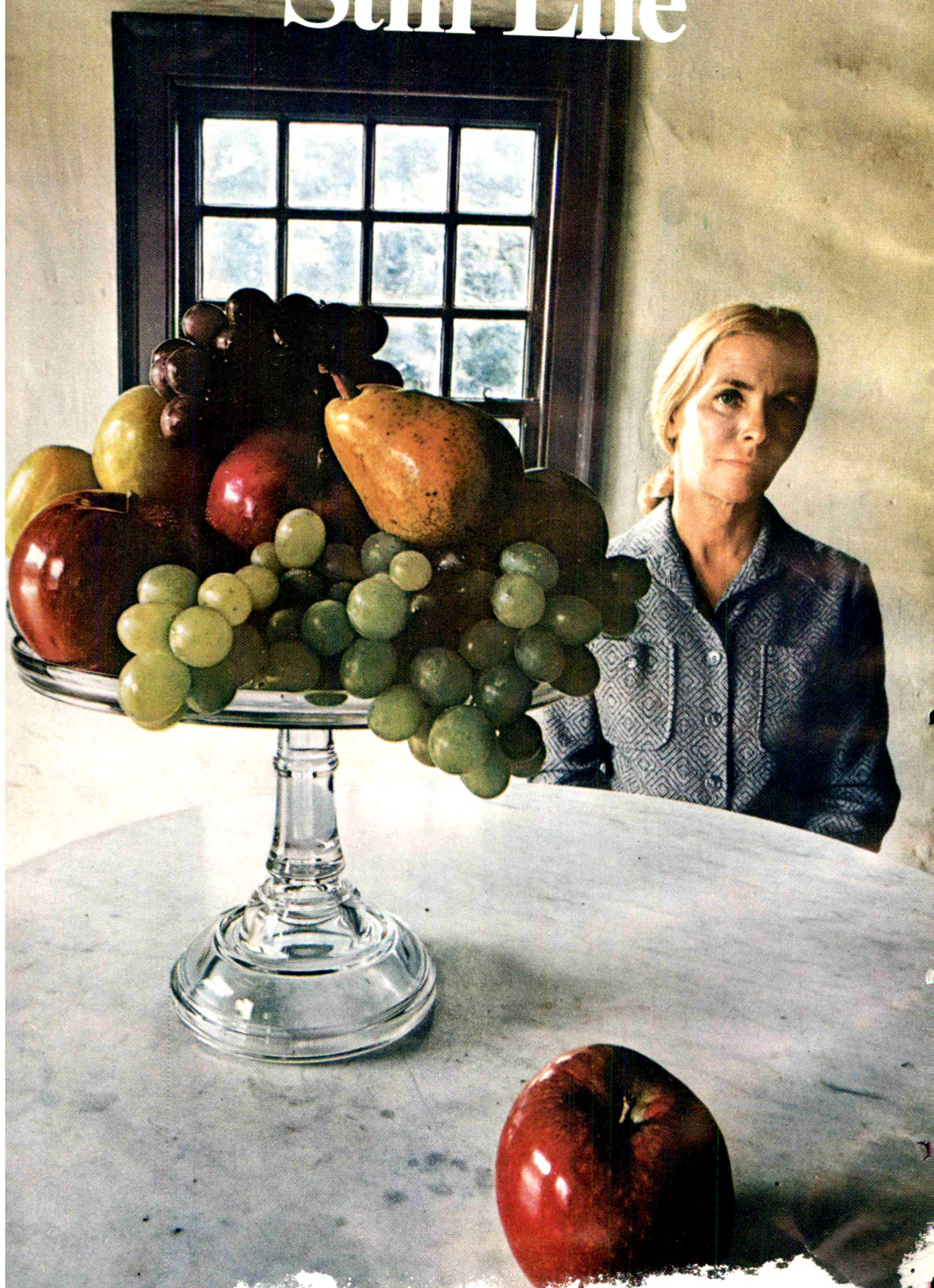
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Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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It may be just a mild depression. But she needs help...and needs it right now.

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better. Ritalin improves mood and outlook, helps the patient get moving again.

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Ritalin[®]

(methylphenidate)

helps overcome the inertia of mild depression*

*This drug has been evaluated as possibly effective for this indication. See brief summary.

Ritalin[®] hydrochloride 
(methylphenidate hydrochloride)
TABLETS

INDICATION

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indication as follows: "Possibly" effective: Mild depression. Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established.

Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored. Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use

effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary.

Periodic CBC and platelet counts are required during prolonged therapy.

common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION

Adults

Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.

Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.

Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4666-3 17

Good News about Depression

...and the abnormal sleep patterns of depressed patients

Many investigators consider disordered sleep one of the most important single factors in depression, and they feel that patterns of sleep disturbance are so typical as to be diagnostic.² Rapid eye movement (REM) and stage 4 sleep are considerably reduced in the depressed patient. Awakenings are frequent, total sleep time is decreased, and patients complain that what sleep they do get does not relieve their fatigue.

A typical pattern of sleep disturbance in depression is illustrated in the above histogram. This patient was one of a series of six studied in the sleep laboratory of William W. K. Zung, M.D. Depression was measured quantitatively with the Self-rating Depression Scale (SDS). The mean SDS index for all six patients prior to treatment was 65, indicating moderate to severe depression. The evaluation of sleep was made by means of all-night EEG and EOG recordings.

The drug used was desipramine hydrochloride.

Results demonstrated that sleep patterns were improved after one week. Sleep cycles were reduced from 10 or 12 to 5 or 6. Total sleep time increased. REM sleep was at first reduced, but at the end of one month returned to predrug levels. All other stages of sleep, including stage 4, were "normalized," and patients reported they had "rested better."

In all six patients the mean SDS index dropped after one week to 57. After four weeks of treatment the index was 42—within the limits of nor-

mal subjects—indicating improvement not only in sleep but in all the symptoms of depression.

References: 1. Zung, W. W. K.: Effect of Antidepressant Drugs on Sleeping and Dreaming. III. On the Depressed Patient. *Biological Psychiatry* 1:283-287, 1969. 2. Zung, W. W. K., et al: The Sleep of the Depressed. *Mental Health Program Reports No. 2*, U.S. Dept. H.E.W. 265-283 (Feb.), 1968.

In Brief:

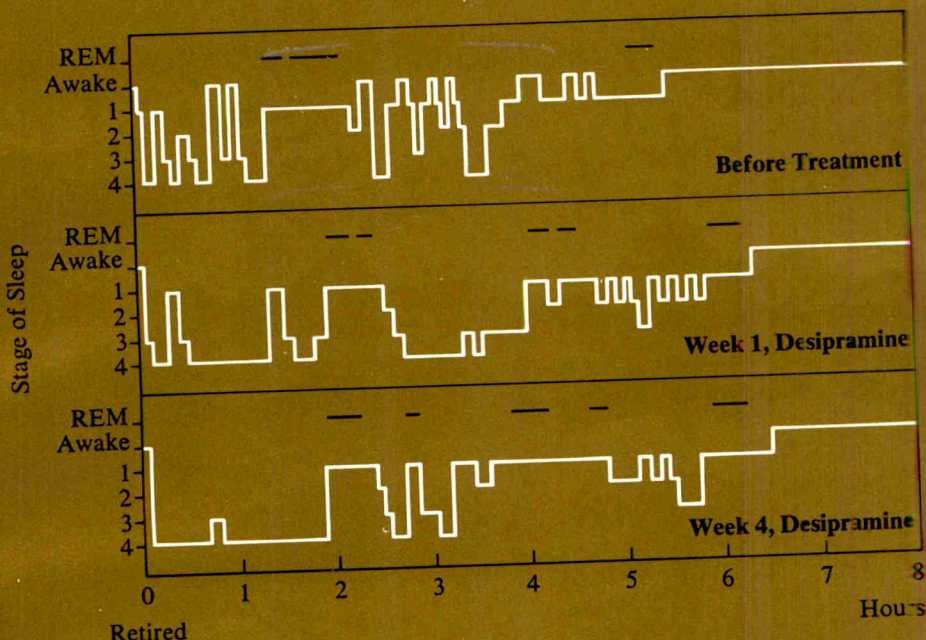
Actions: Norpramin® (desipramine hydrochloride) is an antidepressant drug of the tricyclic type. It has been found in some studies to have a more rapid onset of action than imipramine; antidepressant efficacy is similar though potency on a weight basis may be less. The earliest manifestations consist mainly of an increase in psychomotor activity. Full treatment benefit is seldom attained before the end of the second week.

Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. A patient should be cautioned.

All-night sleep patterns of a depressed patient treated with desipramine (25 mg, q.i.d.), comparing data obtained before treatment and during first and fourth weeks on drug.¹



Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of psychosis in schizophrenic patients. Close supervision and careful adjustment of dosage are required when this drug is given along with anticholinergic or sympathomimetic drugs. While taking this drug, response to alcoholic beverages may be exaggerated. There is limited clinical experience in the concurrent administration of ECT and antidepressant drugs; thus, one should consider the possibility of increased risk relative to benefits. Discontinue as soon as possible prior to elective surgery because of possible cardiovascular effects. Hypertensive episodes have been observed during surgery in patients on desipramine hydrochloride. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is neutropenia.

Adverse Reactions: *Cardiovascular:* hypotension, hypertension, tachycardia, palpitation, arrhythmias, heart block, myocardial infarction, stroke. *Psychiatric:* confusional states (especially in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric pain, bitter taste, abdominal cramps, diarrhea. *Endocrine:* gynecorrhoea in the fe-

male; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: The usual adult dose: 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily; increase to 100 mg. daily if necessary. **Overdosage:** There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

How Supplied: Norpramin® (desipramine hydrochloride) 25 mg., sugar coated tablets, yellow, in bottles of 50, 500 and 1000 tablets. Norpramin® (desipramine hydrochloride) 50 mg., sugar coated tablets, light green, in bottles of 50, 250 and 1000 tablets.

Norpramin®
(desipramine hydrochloride)



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**For graduate student
John R., lying down
to sleep was a real
eye-opener.**





Meet John R., age 33.
B.A., *cum laude*
Ph.D. in the making.

But until recently, it looked as if he might not make it. His problem: insomnia. Clinically confirmed. Unwanted wakefulness every night. It was wreaking havoc with his studies. And with his personal relationships, too.

Quaalude®-300 (methaqualone) helped solve John R.'s problem...but under rather unusual circumstances.

John R. volunteered to participate... along with nine other confirmed insomniacs... in a sleep study¹ of experimental design, single blind, to evaluate Quaalude-300 against placebo. Sequentially, there were three placebo nights, followed by three drug nights, followed by four placebo nights. EEG recordings were obtained continuously from 2300 to 0600 hours. He returned for a second period of 10 days three weeks later.

Goldstein, *et al.*,² reported that two statistically significant benefits of Quaalude-300 were apparent in this particular study.

- Time needed for the insomniacs to fall asleep was reduced.
- Intermittent periods of wakefulness... so common among insomniacs... were shorter when Quaalude was used.

Other clinical studies, plus experience in medical practice throughout the world, have established the therapeutic value of non-barbiturate methaqualone: Quaalude can induce sleep in 10 to 30 minutes; it usually helps produce 6 to 8 hours of restful sleep; Quaalude patients usually awaken easily and without evidence of "hangover."

Side effects reported have been mild, transient and have often proved to be statistically insignificant when compared to placebo effects. Psychological dependence occasionally occurs, physical dependence rarely reported. (See Brief Summary of Prescribing Information.)

Maybe your patients can benefit as John R. did, by your prescribing Quaalude.

Brief Summary of Prescribing Information

Indications: Sleep. Daytime sedation.

Usual Adult Dose: For sleep, 150-300 mg. at bedtime. For patients previously on other hypnotics 300 mg. for five to seven nights. For sedation 75 mg. t.i.d. or q.i.d. Not recommended in children. Dosage should be individualized for aged, debilitated or highly agitated patients.

Overdosage: Acute overdosage may result in delirium and coma, with restlessness and hypertonia progressing to convulsions. Evacuate gastric contents, maintain adequate ventilation and support blood pressure, if necessary. Dialysis may be helpful. Analeptics are contraindicated. Succinylcholine accompanied by assisted respiration has been proposed for prolonged convulsions. Overdoses of methaqualone appear to be less often associated with cardiac or respiratory depression than are overdoses of oral barbiturates, but shock and respiratory arrest may occasionally occur.

Contraindications: Contraindicated in women who are or may become pregnant; or patients with known hypersensitivity.

Warnings: Take hypnotic dose only at bedtime. Not recommended in children. Warn patient or Quaalude® (methaqualone) against driving a car or operating dangerous machinery. Care needed when administered with other sedative, analgesic or psychotropic drugs or alcohol because of possible additive effects. Pending longer clinical experience, Quaalude should not be used continuously for periods exceeding three months. Psychological dependence occasionally occurs. Physical dependence rarely reported. However caution needed with addiction-prone patients.

Precautions: Use with caution and prescribe small quantities in patients with anxiety states where impending depression or suicidal tendencies exist. Give in reduced doses, if at all, in patients with impaired hepatic function.

Adverse Reactions: *Neuropsychiatric:* headache, hangover, fatigue, dizziness, torpor, transient paresthesia of the extremities. An occasional patient has experienced restlessness or anxiety. *Hematologic:* aplastic anemia possibly related to methaqualone has been very rarely reported. *Gastrointestinal:* dry mouth, anorexia, nausea, emesis, epigastric discomfort, diarrhea. *Dermatologic:* diaphoresis, bromhidrosis, exanthema. Urticaria has been particularly well documented.

Supplied: Quaalude-150 (150 mg. white, scored tablets). Quaalude-300 (300 mg. white, scored tablets)

Consult complete literature before prescribing.

1. A Comparative Study of the Effects of Methaqualone... on Sleep in Male Chronic Insomniacs, Goldstein L. *et al.*: *J. Clin. Pharmacol* 10: 258-268, 1970.

2. An Analysis of Effects of Methaqualone... on Sleep in Insomniac Subjects, Goldstein, L. *et al.*: *Res. Communications in Chem. Path. and Pharmacol.* 2: 927-933, 1971.

a non-barbiturate
Quaalude®-300
(methaqualone) 300 mg. tablet

For a good morning after a sleep-through night

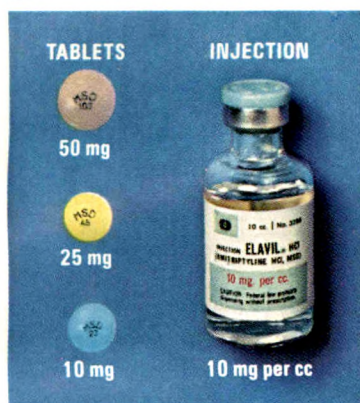
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ELAVIL®
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NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Should not be given to patients who have received an MAOI within two weeks.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises and deaths have occurred. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established, in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as a phenothiazine, may be administered concurrently.

close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns, extrapyramidal symptoms; tinnitus. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. **Other:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000 and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 cc.

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For more detailed information, consult your MSD representative or see the Direction Circular Merck Sharp & Dohme, Division of Merck & Co., Point, Pa. 19486



When high levels of psychic tension must be reduced

Valium (diazepam) can relieve tension-induced symptoms in cases of severe and repeated overreaction to stress, as well as in psychoneurotic states manifested by overwhelming anxiety alone or with secondary depressive symptoms. Ten milligrams, *t.i.d.* or *q.i.d.*, can reduce high levels of psychic tension and thereby may serve as a valuable adjunct to your program of psychotherapy.

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Prompt effective action

Significant improvement with Valium usually becomes apparent during the first few days of therapy, although some patients may require more time to obtain a clear-cut response.

Titratable dosage

When severe symptoms of psychic tension have subsided, therapy with Valium (diazepam) may be discontinued, or continued as needed with the 2-mg or 5-mg tablets, *t.i.d.* or *q.i.d.*

Excellent tolerance

In the usual dosage range, Valium is generally well tolerated. The most frequently reported side effects have been drowsiness, ataxia and fatigue. Caution patient against engaging in hazardous occupations or driving during Valium therapy. Consider Valium whenever you ascertain the need for an antianxiety agent in your total management of clinically significant psychic tension states.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

to help relieve severe psychic tension

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Foreword by **JULES H. MASSERMAN, M.D.**, *Center for Advanced Study in the Behavioral Sciences, Chicago*

Those psychiatrists willing and able to challenge traditional methods and myths will relish this powerfully innovative book which covers all aspects of human behavior in a highly untraditional manner. Throughout the book the author effectively relates the major aspects of the human condition to the practice of psychiatry and to man's behavior. Mental processes, concepts of self, communication, languages, and historical and cultural evolution are vividly discussed. In a superb section on sexuality, the author attempts to desensitize the therapist to the numerous varieties of sexual behavior by means of thoughtful discussions and by aesthetically pleasing illustrations of sexual intercourse in its many forms. In the section on clinical practice the focus is again on the therapist-patient relationship. The author denounces arbitrary labeling of disorders and attempts to develop in the therapist a deeper concern for the patient's welfare and interests. This totally engrossing portion is written in the lively style found throughout the book and is illustrated with numerous case descriptions.

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**SEXUAL BEHAVIORS: Social, Clinical, and Legal
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By 24 Authors

Edited by **H. L. P. RESNIK, M.D.**, *Chief, Section on Crisis Intervention, Suicide, and Mental Health Emergencies, National Institute of Mental Health, Rockville, Maryland*, and **MARVIN E. WOLFGANG, Ph.D.**, *Director, Center for Studies in Criminology and Criminal Law, University of Pennsylvania, Philadelphia*

Psychiatrists faced with preparing a clinical evaluation of sexual offenders of the law will find this new book indispensable. It is a necessity for the psychotherapist who is swept into procedures for pretrial diagnosis, recommendation for legal disposition, and finally treatment of the offender. In this volume the writings of recognized authorities encompass both the traditional and the newer viewpoints and treatment techniques. Sociological, anthropological, legal, and medical issues are covered. Consideration is given to society's responsibility, individual behavior, the role of the victim, and the gamut of illegal sexual behavior. Chapters cover such topics as the therapeutic encounter, the psychodynamic approach to sex deviations, behavior therapy techniques, institutional group therapy, and the therapeutic use of androgen-depleting hormone.

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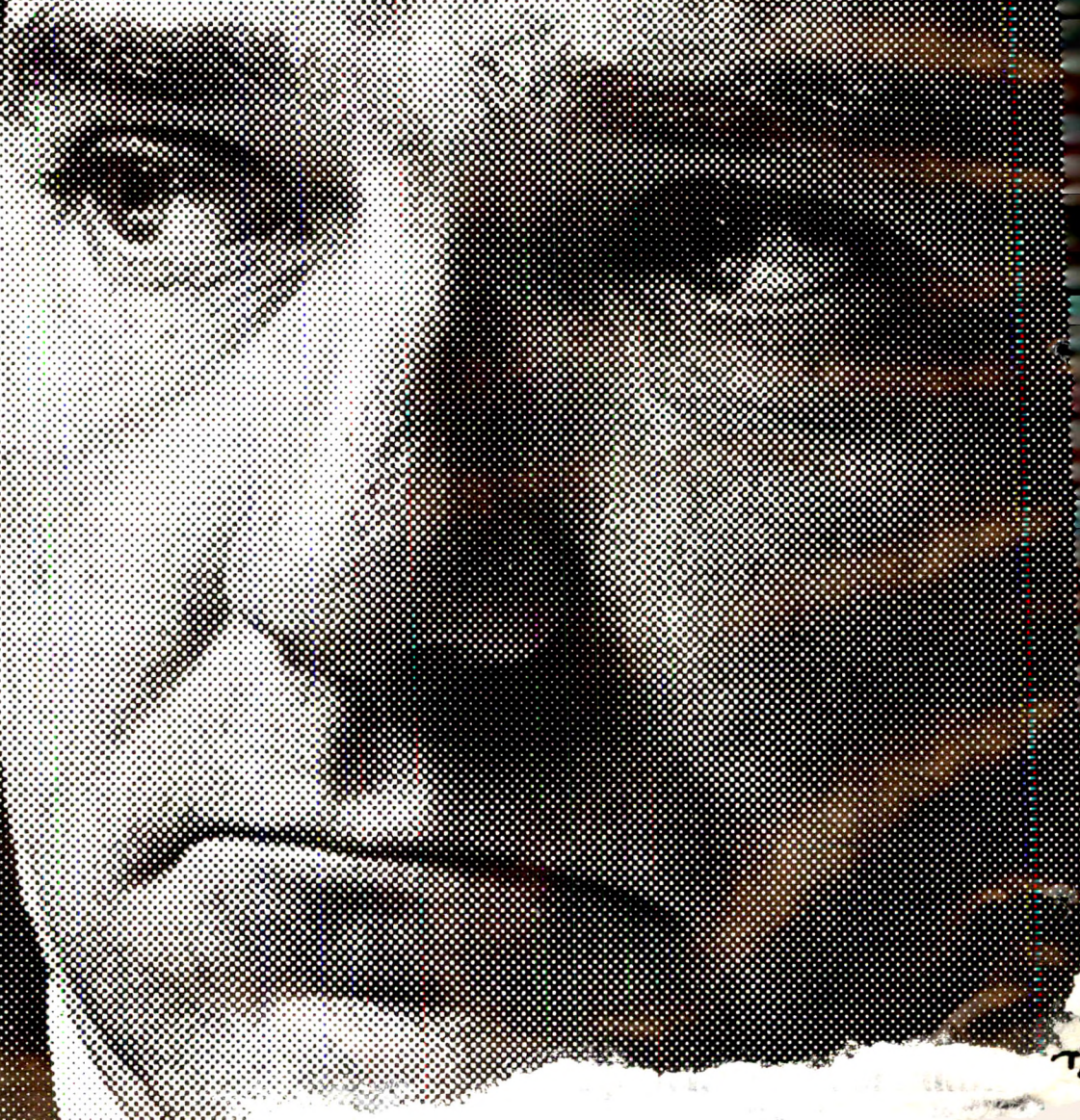
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Into each life some rain must fall but George Harris expects a downpour every day.

Anxiety can be a normal response to a stressful situation. But when inappropriate anxiety becomes a way of life, medication is often indicated.

For the patient suffering from chronic neurotic anxiety, 'Stelazine' offers convenient b.i.d. dosage with no danger of habituation. And, since 'Stelazine' usually acts without sedation, people like George Harris can continue functioning while under treatment.

Stelazine® brand of trifluoperazine HCl in chronic neurotic anxiety*

Tablets:
1 mg., 2 mg.,
5 mg., 10 mg.

*'Stelazine' has been evaluated as possibly effective for this indication. See Brief Summary.

Before prescribing, see complete prescribing information, including symptoms and treatment of overdosage, in SK&F literature or PDR.

* Indications

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of the manifestations of psychotic disorders.

Possibly effective: To control excessive anxiety, tension and agitation as seen in neuroses or associated with somatic conditions.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose or greatly depressed states due to C.N.S. depressants; blood dyscrasias; bone marrow depression; liver damage.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery), especially during the first few days' therapy.

Use in pregnancy only when necessary for patient's welfare.

Precautions: Use cautiously in angina. Avoid high doses and parenteral administration when cardiovascular system is impaired. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Additive effect is possible with other C.N.S. depressants. Prolonged administration of high doses may result in cumulative effects with severe C.N.S. or vasomotor symptoms. If retinal changes occur, discontinue drug. Agranulocytosis, thrombocytopenia, cholestatic jaundice, liver damage.

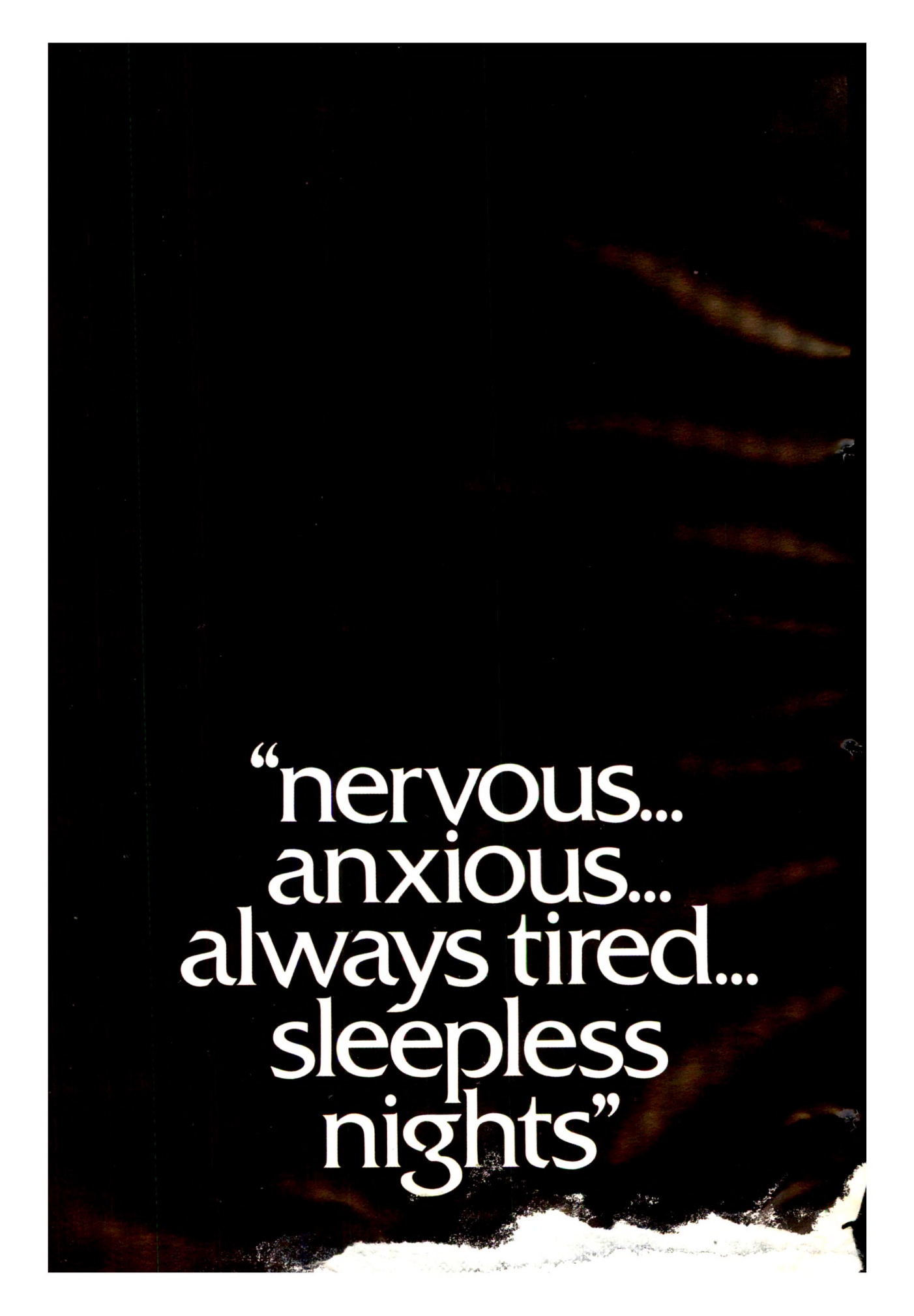
Adverse Reactions: Drowsiness, dizziness, skin reactions, rash, dry mouth, insomnia, amenorrhea, fatigue, muscular weakness, anorexia, lactation, blurred vision. Neuromuscular (extrapyramidal) reactions: motor restlessness, dystonias, pseudo-parkinsonism, persistent tardive dyskinesia.

Other adverse reactions reported with Stelazine (trifluoperazine HCl, SK&F) or other phenothiazines: Some adverse effects are more frequent or intense in specific disorders (e.g., mitral insufficiency or pheochromocytoma).

Grand mal convulsions; altered cerebrospinal fluid proteins; cerebral edema; prolongation and intensification of the action of C.N.S. depressants, atropine, heat, and organophosphorus insecticides; nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, inhibition of ejaculation; reactivation of psychotic processes, catatonic-like states; hypotension (sometimes fatal); cardiac arrest; leukopenia, eosinophilia, pancytopenia, agranulocytosis, thrombocytopenic purpura; jaundice, biliary stasis; menstrual irregularities, galactorrhea, gynecomastia, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis; asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions; peripheral edema; reversed epinephrine effect; hyperpyrexia; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits. EKG changes have been reported, but relationship to myocardial damage is not confirmed. Discontinue long-term, high-dose therapy gradually. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 1 mg., 2 mg., 5 mg. and 10 mg., in bottles of 100; Injection, 2 mg./ml.; and Concentrate, 10 mg./ml.

Manufactured and distributed by SK&F Co., Carolina, P.R. 00630, under Stelazine® trademark license from Smith Kline & French Laboratories, Philadelphia, Pa.



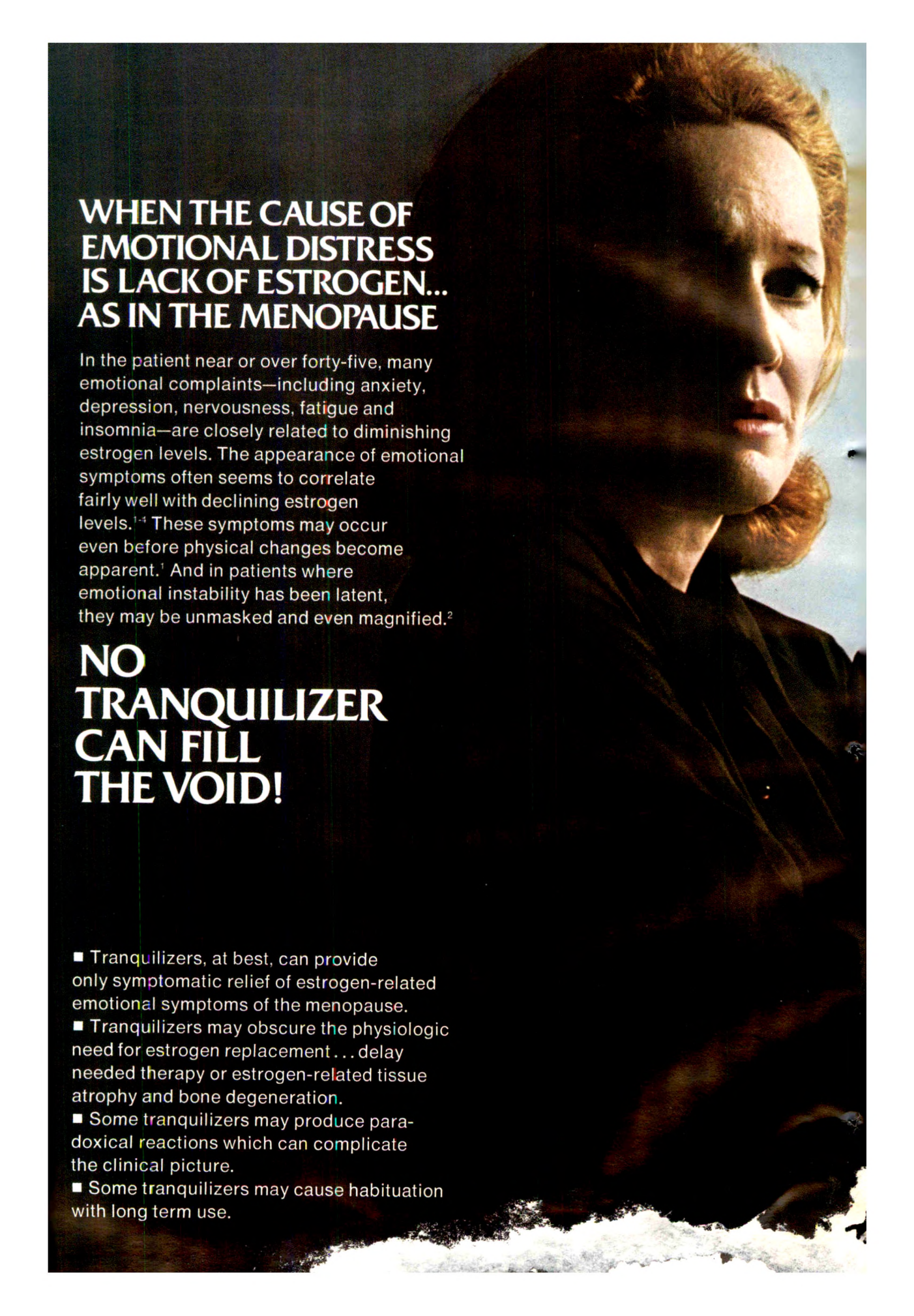
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In the patient near or over forty-five, many emotional complaints—including anxiety, depression, nervousness, fatigue and insomnia—are closely related to diminishing estrogen levels. The appearance of emotional symptoms often seems to correlate fairly well with declining estrogen levels.¹⁻⁴ These symptoms may occur even before physical changes become apparent.¹ And in patients where emotional instability has been latent, they may be unmasked and even magnified.²

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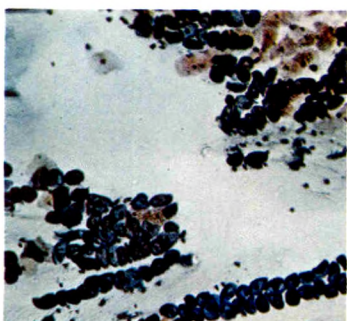
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*Case report on file, Medical Department, Ayerst Laboratories, New York, N.Y.

See last page of advertisement for prescribing information.

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Dosage and Administration: Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

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References: 1. Rhoades, F.P.: *J. Amer. Geriat. Soc.* 15:346 (Apr.) 1967. 2. Greenblatt, R.B., in Conn, H.F. (Ed.): *Current Therapy* 1970, Philadelphia, W.B. Saunders Company, 1970, p. 757. 3. Kerr, M.D.: *Mod. Treatm.* 5:587 (May) 1968. 4. Astwood, E.B., in Goodman, L.S., and Gilman, A. (Eds.): *The Pharmacological Basis of Therapeutics*, ed. 4, New York, The Macmillan Company, 1970, Chap. 69, p. 1538 ff. 5. Penningroth, R.P., and Tournay, G.: *Postgrad. Med.* 46:118 (July) 1969. 6. Kupperman, H.S.: *Medical Aspects of Human Sexuality* 1:64 (Sept.) 1967. 7. Tramont, C.B.: *Geriatrics* 21:212 (Nov.) 1966.

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Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema.

Skin—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single case described as parotid swelling.

The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia, occasionally persisting for several months or years especially in elderly patients with brain damage. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, weight gain, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

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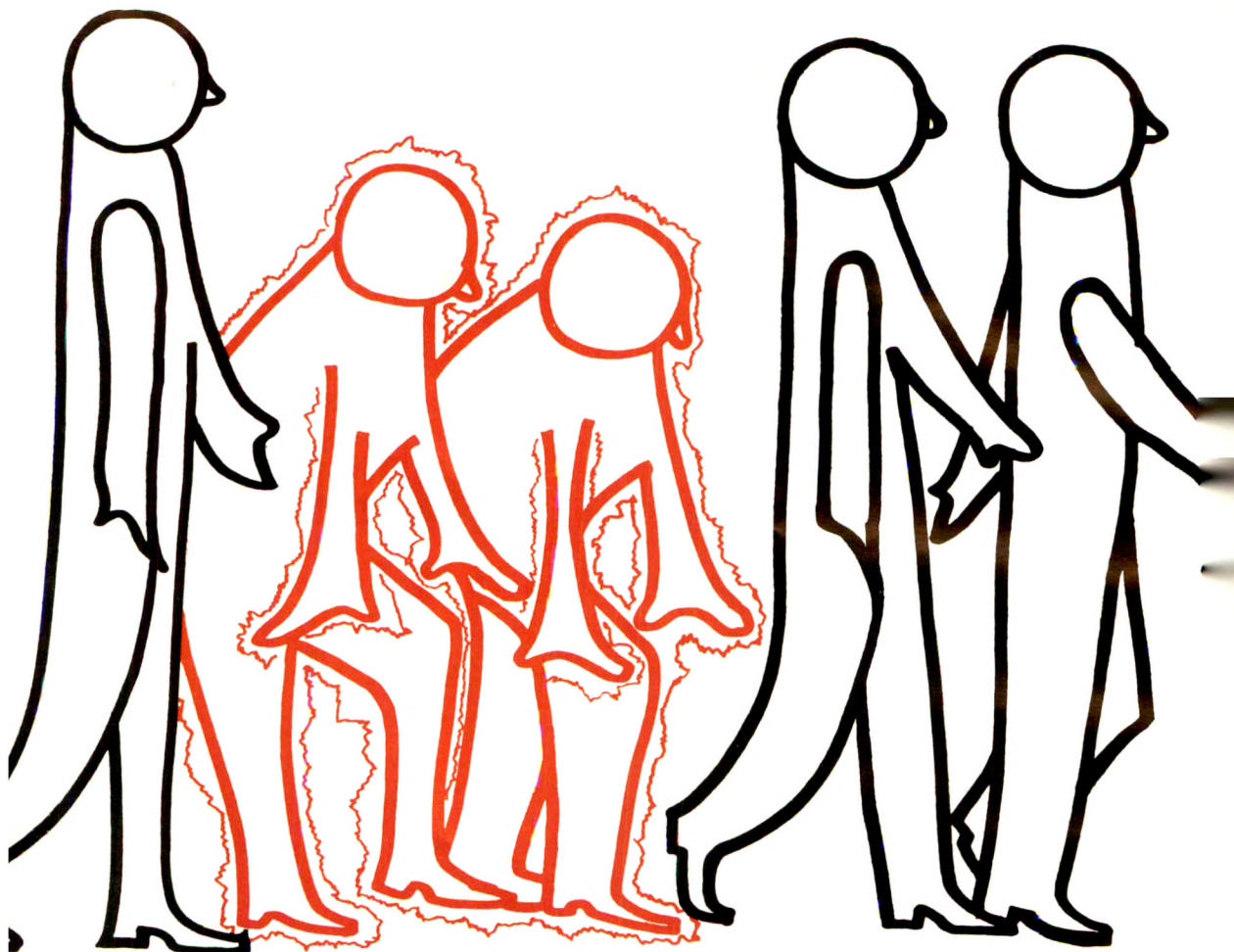


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THE AMERICAN JOURNAL OF PSYCHIATRY

The Phases of Adult Life: A Study in Developmental Psychology

BY ROGER L. GOULD, M.D.

The author believes that adulthood as a developmental period has been conceptually and empirically ignored in the psychiatric literature with but few exceptions. Two studies on the subject are reported: an observational study of psychiatric outpatients seen in age-homogeneous groups and a questionnaire study of 524 nonpatients. The author found discriminations between age groupings that center largely on the subjects' sense of time and on their attitudes toward self and others in relation to that variable.

IN THE WORK that is to be reported in this paper, the assumptions have been made that people continue to change over the period of time considered to be adulthood and that developmental phases may be found during the adult span of life if they are looked for properly. The focus of this work is on the sequential change that takes place with time rather than on a full description of any one stage. The work is intended to be descriptive and the hypotheses to be generating. The results of direct observations of patients and a questionnaire given to nonpatients will be presented.

When Freud began his exploration of the depths of the mind, he first found the submerged child in the supposed-to-be adult (1).

He later carried out, against the resistance of the civilized world, the bold rescue of the sentient child from the sterile and static adultomorphism preferred by his culture (2). This two-fold discovery forced the world to abandon in part the preferred view that adults populate the world and act rationally as adults should. It is interesting to note that the preferred view that adults are rational is a strongly held prejudice of mankind and has fit well the needs of a Christian theology and a structure of civilization built on the law. It is against this ingrained view of man as a fully formed, static, rational adult that the observations and insights of dynamic psychiatry and psychoanalysis struggle.

Though adolescence has been shown, since the time of Freud, to be a period of dynamic and vital growth, we have not made any significant changes in our conceptualization of the periods of adulthood following the identity struggle of youth. We have not proposed any coherent view of the procession through time of the adult or of psychological growth and change as a function of time in the adult years. Adults are conceived of as being in dynamic conflict, but without direction. The resolution of conflict is thought to lead to higher levels of integration and adaptiveness, but not into a new personality era. Adulthood is still seen as a period of marking time and is not seen as a progression of stages much like the phases of rapid and slow growth of childhood and adolescence.

We have learned to understand the intrapsychic struggles of individuation in childhood and adolescence as struggles keyed by the imposed role task of progressive separation from objects and pushed from

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Computer assistance for this work was obtained from the Health Sciences Computing Facility at UCLA, which is funded by Public Health Service grant RR-3 from the Division of Research Resources, National Institutes of Health.

within by a complemental evolution of internally programmed biological changes. Both separation from objects and changes in our biological equipment are mediated by time. Why, in our conceptualizations, do we seem to assume that time no longer functions systematically after 21 years of age and to rely henceforth on thematic and adventitious factors to anchor our understanding of change? After all, both object and biological changes continue throughout life. In fact, object changes are even more dramatic in the period after 21 than before 21.

If we would take ego autonomy as our ideal state of individuation, we would have to consider under what conditions ego autonomy prevails. To be autonomous while living alone is entirely different from that in daily living with a spouse. To maintain autonomy while sorting out the pressing demands of spouse and children and employer is a task of greater magnitude than previous tasks and requires a more highly developed psychic apparatus if an optimal level of individuation is to be maintained. There is a difference between living in the world with live, healthy, and powerful parents in the background ready to support you and living with enfeebled, dependent parents in the background. If anything, the changes that take place in one's parents and in one's children would suggest that time-mediated object changes are of the utmost importance during the adult years and that the necessity for change is as imperative as in the period before age 21. From a commonsense point of view, then, there would be no justification for our conceptualizations to imply that time no longer functions systematically after 21 years of age and no justification for our theories of change to rely on thematic and adventitious factors as the essential elements.

Survey of the Literature

Although adulthood as a topic for developmental psychology has largely been ignored, several contributions have been made to the topic. Erikson's work on the seven stages of man (3) is probably the best known of these efforts. He considers his last three stages to be the stages of adulthood: the first adult stage is Intimacy and Distantiation versus Self-Absorption. It represents the success or failure in one's ability to be truly

open and capable of a "trusting fellowship" rather than formal separateness or pseudo-intimacy. This is the task of young adults before they work on the next task, Generativity versus Stagnation. In this phase of adulthood, roughly spanning the mid-20s on, the individual must create for himself a continuing giving of himself to his world in a creative, caretaking, participatory way that is progressive, in order to avoid the pit of stagnation. The final stage, Integrity versus Despair, includes the span from later adulthood to death; in this stage the individual comes to grips with his own life as "one's one and only life cycle." Erikson's description of these life phases is very brief. He encourages others to flesh them out with detailed investigations and descriptions. When we compare these skeletal sections on adulthood with his fuller previous sections on childhood, we find vivid evidence that adulthood as a topic has been neglected. Erikson has broadly stroked the thematic dilemmas of being an adult while directing our attention to adulthood as a part of the series of phases extending throughout the life span.

T. Benedek (4) has added an in-depth view of the psychology of being a parent in her work "Parenthood as a Developmental Phase." She notes that there is an emotional normative symbiosis between parent and child that is based on the parent's prior experience of childhood and that operates through the mental principle that "the introjected object is merged with the introjected self in the drive experience and thereby object representations and self-representations are established in inseparable connection with each other." That is, the parent is capable of structural change because in the deep part of his mind the experiences he has with his child are opportunities to rework intimately tied, structure-determining memories of his own childhood. This is all made possible by a kind of limited regression and emotional symbiosis on the part of the adult parent to the level of the developing child. This normative regression and blurring of self-definition is a detailed look at what Erikson called mutuality during the stage of generativity.

Rangell (5), in his paper "The Role of the Parent in the Oedipus Complex," pointed out that the oedipus complex is a structure that continues into later life and organizes much of adult emotional behavior. His case exam-

ples illustrate particularly well the reversal of themes after the adult has passed his prime. The parent finds himself envious of his child, who is seen as being at the acme of instinctual potency.

Jacques (6) has offered a penetrating appraisal of the mid-life crisis occurring in the mid-30s and resolving itself in the early and mid-40s. He adds to his clinical observation and case example the weight of the words and lives of famous artists and writers. He discusses this crisis period as a painful confrontation with the inevitability of death and the finitude of time. He sees it as a period requiring that the depressive position be worked through again. The outcome depends on the balance of life-and-death forces that were structuralized in the style of living before the crisis, and its success or failure is judged in terms identical with those of Erikson's stage of Integrity versus Despair.

All these analytic contributions bring important clinical insights to bear on the subject of adult changes over time and suggest areas for more rigorous investigations. They lack, however, the base of detailed comprehensive data on the entire adult life span for a large number of people who can be compared on the same axis of measurement.

Other investigators have attempted to gather this base of data through three fundamentally different approaches. Bühler has spent a lifetime collecting individual biographies of creative and everyday people and has conceptualized her material predominantly from the view of value changes over the life span. This is the longitudinal approach. She finds that the phasic phenomena of the life cycle, as reflected in her biographical studies (7), can best be described as a three-phasic process: "1) a growth period from birth until the organism is fully developed; 2) a stationary growth period during which the organism's power to maintain itself and develop is equal to the forces of decline; and 3) a last period of decline" (p. 13). Each phase can be broken into subphases and given rough time zones that prescribe the orientation of the self and organize the goals of living for that time period.

Neugarten and associates (8), in a large field study in Kansas City, studied 710 people in the mid-1950s both by interview and by projective test schedules. They concentrated on middle life and their sample was from 40

to 90 years old:

When all of the studies in this book are considered together, it appears that they form two groups. Those in which chronological age provides order in the data are those when the focus was on the intrapsychic, the processes of the personality that are not readily available to awareness or conscious control and which do not have direct expression in overt patterns of social behavior. The second group, those in which individual differences are relatively independent of age, are those where the focus was on more purposive processes in the personality, processes in which attempted control of the self and of the life situation are conspicuous elements (p. 192).

Another conclusion from these studies is that there is an increase of interiority as aging advances that is clearly demonstrable by the mid-40s and that there is a decrease in personality complexity with "an increasing dedication to a central core of values and to a set of habit patterns and a sloughing off of earlier cathexes which lose saliency for the individual . . ." (p. 198).

In a study concerning the changing time perspective in middle age, Dr. Neugarten (9) reported:

Both sexes, although men more than women, talked of the new difference in the way time is perceived. Life is restructured in terms of time-left-to-live rather than time-since-birth. Not only the reversal in directionality but the awareness that time is finite is a particularly conspicuous feature of middle age. Thus, "you hear so much about deaths that seem premature. That's one of the changes that comes over you over the years. Young fellows never give it a thought. . . ." The recognition that there is "only so much time left" was a frequent theme in the interviews. In referring to the death of a contemporary, one man said, "there is now the realization that death is very real. Those things don't quite penetrate when you're in your twenties and you think that life is all ahead of you. Now you know that death will come to you, too" (9, p. 97).

Another interviewee added: "It is as if there are two mirrors before me, each held at a partial angle. I see part of myself in my mother who is growing old, and part of her in me. In the other mirror, I see part of myself in my daughter. I have had some dramatic insights, just from looking in those mirrors. . . . It is a set of revelations that I suppose can only come when you are in the middle of three generations" (9, p. 98).

Dr. Neugarten noted that her studies have

relevance for a theory of the life cycle in two ways:

First, in indicating that the age structure of a society, the internalization of age-norms, and age-group identifications are important dimensions of the social and cultural *context* in which the course of the individual life line must be viewed; Second, because these concepts point to at least one additional way of structuring the passage of time in the life span of the individual, *providing a time clock* that can be superimposed over the biological clock, together they help us to comprehend the life cycle. The major punctuation marks in the adult life line tend (those, that is, which are orderly and sequential) to be more often social than biological—or, if biologically based, they are often biological events that occur to significant others rather than to oneself, like grandparenthood or widowhood (9, p. 146).

The third method adopted by psychologists has been to study specific questions over time—the ages of greatest happiness, most mental problems, most hospitalizations, greatest change in specific functions, most divorces, greatest contentment with age, etc. The composite of all of these studies could shed light on the life cycle as a whole. The number of such studies is great and they comprise a large percentage of the psychological and sociological literature. Several authors (10–16) have contributed studies that are pertinent to the issues in this paper.

Study 1

Only Bühler and Erikson have looked at the whole life span, but neither of them supplies us with exactly the kind of information we are looking for. Erikson becomes quite sweeping and thematic in his approach to adulthood after the identity crisis and Bühler applies a rational overview of the life span in terms of physiological stages, but neither bears down on the chronological change in the subjective “sense of the world.” By “subjective sense of the world” I mean the out-of-focus, interior, gut-level organizing percepts of self and nonself, safety, time, size, etc., that make up the background tone of daily living and shape the attitudes and value base from which decisions and action emanate. Such a vague but central phenomenon requires a careful and thorough investigation (as well as a more precise definition) of individuals, with some optimal combination of the methods of psychoanalytic investigation and Neugarten’s

methods. Before considering such an effort, we decided to inspect the terrain of the whole adult life span to see whether we could catalog the obvious and construct a platform from which to begin. This section of the paper presents the results of this attempt.

Method

We started with a simple descriptive effort. During 1968, all of the patients who were in group therapy at the UCLA Psychiatric Outpatient Clinic were assigned to homogeneous age groups. There were seven groups, composed of the following age ranges: 16–18, 18–22, 22–28, 29–34, 35–43, 43–50, and 50–60 or more. At the end of six months a second set of seven groups was constituted and observed. These 14 groups were treated by 14 third-year residents as part of their psychiatric training. Each of the 14 groups was observed continuously by one of the study group staff, either as cotherapists or as supervisors via tape-recordings. The ten study group members (psychiatrists, psychologists, and an anthropologist) met every two weeks to report their observations and to make simple first-order comparisons.

Although many detailed observations were made, in order to begin our study on solid and safe ground we asked each member to characterize the age group he was studying on the simplest, most self-evident level. We asked for a level of psychological sophistication so low that any naïve, honest observer watching the group would have to agree with the description. We were apparently successful in achieving this goal of simplicity and replicability by two simple measures. With the composition of a second set of groups after six months, the staff rotated age groups and were able to confirm the observations of their colleagues on new groups. The following summer eight first-year medical students, psychologically naïve but bright, listened to the tapes of the group sessions and picked out the same central and salient characteristics.

Results

The observations made about each phase of life are familiar, often anticipated by common sense; many can easily be corroborated by everyday experience and anecdotal accounts. It is the interrelationship of each age phase with the others that is unique and that gives us an empirically based portrayal

of the changes in the subjective "sense of the world" or "posturing of the self" over time.

In the group aged 16 to 18, we are unavoidably struck with the theme that was like a motto: "We have to get away from our parents." The theme is loud and repetitively verbalized but not connected with any complementary action. They are all safely part of their families and consider themselves more as family members than as true individuals. They see the future as some vague time "out there" when they will be liberated and mainly have a fantasy conception of what their own adulthood will be like. Their autonomy is precarious, often fortified by negativism, and subject to erosion from moment to moment. Although they long for deep close relationships with peers, the closeness most often found is instantaneous and unstable and is followed by a temporary rebound back to parents.

In the next age group, 18-22, we find a continuation of the theme "We have to get away from our parents" but from a different position. They feel themselves to be halfway out of the family and are worried that they will be reclaimed by the family pull and not make it out completely. They are involved in many kinds of implementing actions—living away from home at school, working, paying rent, owning their own cars—but are not quite totally committed to their current time base since it is not quite adult yet. The real living is just around the corner. They are especially supportive of each other in the group and talk of recreating with their peers the family they are leaving. The peer group becomes the ally that will help them out of the family, but in itself it becomes a new threat that endangers the pureness of their own authentic emerging beliefs by imposing the group belief as an essential for membership and alliance. They see their intimates as betrayers if the intimate person's way of thinking is not identical to their own or if the intimate cannot perform all of the soothing functions that the family had performed. Their own autonomy is felt to be established, but in jeopardy. They perceive a vague feeling that they have to keep a lid on themselves lest anger, fear, or depression escape.

There is a considerable shift in the next group, 22-28. They feel quite established and autonomous and separate from their families and feel they are engaged in the work of being

adults. They particularly feel that what they are doing is the true course in life and there is very little energy wasted in considering whether their general commitments are the right ones or not. Most of their energy is spent mastering what they are supposed to be. They feel their "self" to be well-defined, even if they are not fully satisfied with it. They see their parents as people with whom they want to establish a *modus vivendi*, but to whom they still have to prove their competence as adults. The peers are still important but not to be relied on as much as self-reliance and, although they can still be hurt by a peer's response to them, it is not seen as potentially devastating. The spouse is seen as a person who may not be mature enough now, but with whom there is a commitment to make a marriage work. There is a definite feeling that "now" is the time for living as well as growing and building for the future. Extreme emotions are still guarded against, but now not so much to prevent a leak as to prevent disappointment. It is not sensible to get too high and excited because it may be followed by a low. The emphasis is on modulating the emotional tone in an experimental effort to learn the proper tone for adult life.

The following group, 29-34, seems to have quite a different experience of their world. Whereas those aged 22 to 28 felt they were on the relatively unquestioned true course of life and could devote themselves to the mastery of what they were supposed to be, the 29-34 age group was beginning to question: "What is this life all about now that I am doing what I am supposed to?" and "Is what I am the only way for me to be?" Marriage and career lines have been established and young children are growing, but some inner aspect is striving to be accounted for. They feel weary of devoting themselves to the task of being what they are supposed to (although they continue on), and just want to be what they are. In particular, there is a dawning awareness that their will alone is not all of them, and that inner forces reproduce patterns of behavior and relationships that they don't particularly want to exist but can no longer ignore or will away. They no longer see the necessity to prove themselves to their parents or highlight their differences, and in such a situation feel free to acknowledge and accept parts of themselves as being like and coming from their parents. They often see

their spouses as preventing this new emergence by acting as witness to their supposed-to-be former self and not being willing enough to see the new self. A most poignant desire is to be accepted by the spouse "for what I am." Their children are becoming companions and love objects.

Just as they want to be accepted for "what I am," they want to accept their own children for "what they are becoming" and not impose roles on them. This conscious attempt to let their children grow freely is interfered with by a series of confusing temporary identifications with their growing children. Often the anecdotes of their children's behavior described in the group sessions were so commingled with similar memories from their own pasts that it was unclear who felt what.

In the subsequent age group, 35-43, there is a continued look within and an existential questioning of self, values, and life itself, but with a change of tone toward quiet desperation and an increasing awareness of a time squeeze. This tone applies to themselves, their parents, and their children. Instead of "I just want to be" with a sense of timelessness, there is "Have I done the right thing?"; "Is there time to change?" The children are seen as emerging end products of their parenting and reflections of their worth. There is a sense that not only is there little time left to shape the behavior of their adolescent children but there is uncertainty about which value lines to follow in the shaping and how fast their control over the children is waning. Their own parents at this stage turn more toward them and there is a muffled renewal of old conflict lines that is kept suppressed by the thought that, since the parents are getting older and time is running out for them, direct criticism would be guilt-provoking. The sense of time during this stage emphasizes the finitude of time and there is an eye toward the past, present, and future equally. Under this time pressure of conflict and questioning, the person looks to the spouse, who is often in a similar life position and is looking for the same support. Work is often looked to as offering the hope of compensation for all of this, but in a fantasy way—"one last chance to make it big."

In the 43- to 50-year-old group, we see some definite changes from the 35- to 43-year-old group and in some ways it is as though the issues anticipated are now being lived with.

That is, in the earlier group the emerging sense that time is finite is hedged by the compensating feeling that there is still time if you hurry to make some dreams come true, but in the 40s it is not hedged. Finite time is resigned to as reality and as not so malleable by self-illusions. The "die is cast" feeling is present and is seen as a relief from the internal tearing apart of the immediately previous years even though it is a bitter pill to swallow. They feel as if their personalities are pretty well set and on occasion are vocally critical of their parents and tend to blame them for their life problems. They are eager to have social activities and friends, but more on a superficial basis and more tinged with negative, competitive casts. They are still actively involved with their young adult children, but now not as ones emerging but as ones who have emerged and are separate. They tend to be watchful of their children's adult progress in a specific style, i.e., with a readiness to find the error in their ways. They very actively look for sympathy and affection from their spouses, who in many ways they seem to be dependent on in a mode similar to that of their former dependency on parents.

In the 50s there is a mellowing and warming up. The negative cast of the 40s diminishes in their relationships to themselves, their parents, their children, and their friends. Their parents are no longer the cause of their problems, but are affectionately called "Mom" and "Dad." The children's lives are now seen as potential sources of warm comfort and satisfaction and they are concerned not so much with their children's achievements as with their happiness in personal terms. They value their own spouses more and look within themselves at their own feelings and emotions, although not with the critical "time pressure" eye of the late 30s or with the infinite omnipotentiality of the early 30s but with a more self-accepting attitude of continued learning from a position of general stability. The spouse is seen now as a valuable source of companionship in life and less like a parent or source of supplies. Criticisms of the previous years are realigned to take into account this central change. However, all is not as comfortable as it might appear from the description of the 50s so far. There is a narrow time span, with little concern for the past or future, which seems to be related to the unmentioned but imminent presence of mor-

tality. With this there is a renewed questioning about the meaningfulness of life as well as a review of one's own work contributions to the world. In addition, there is a hunger for personal relationships from a position of indelible uniqueness but a necessity to stay away from emotionally laden topics and a concentration on petty annoyances, health topics, and an unexpected guilty shadow about personal sexual views.

Study II

The results of Study I are given descriptively and stand for themselves. We were impressed by the facts that differences among age groups could be found by the use of simple observation and that the differences seemed quite substantial. We were not at all confident about the specificity of our age groupings nor about the generalizability of our observations to a non-help-seeking population. We had no socioeconomic data for disaggregating our sample into subgroups. This second study adds more information on age specificity and generalizability but does not contribute to our knowledge of possible subgroup variability based on such factors as sex, income, race, religion, or occupation.

Method

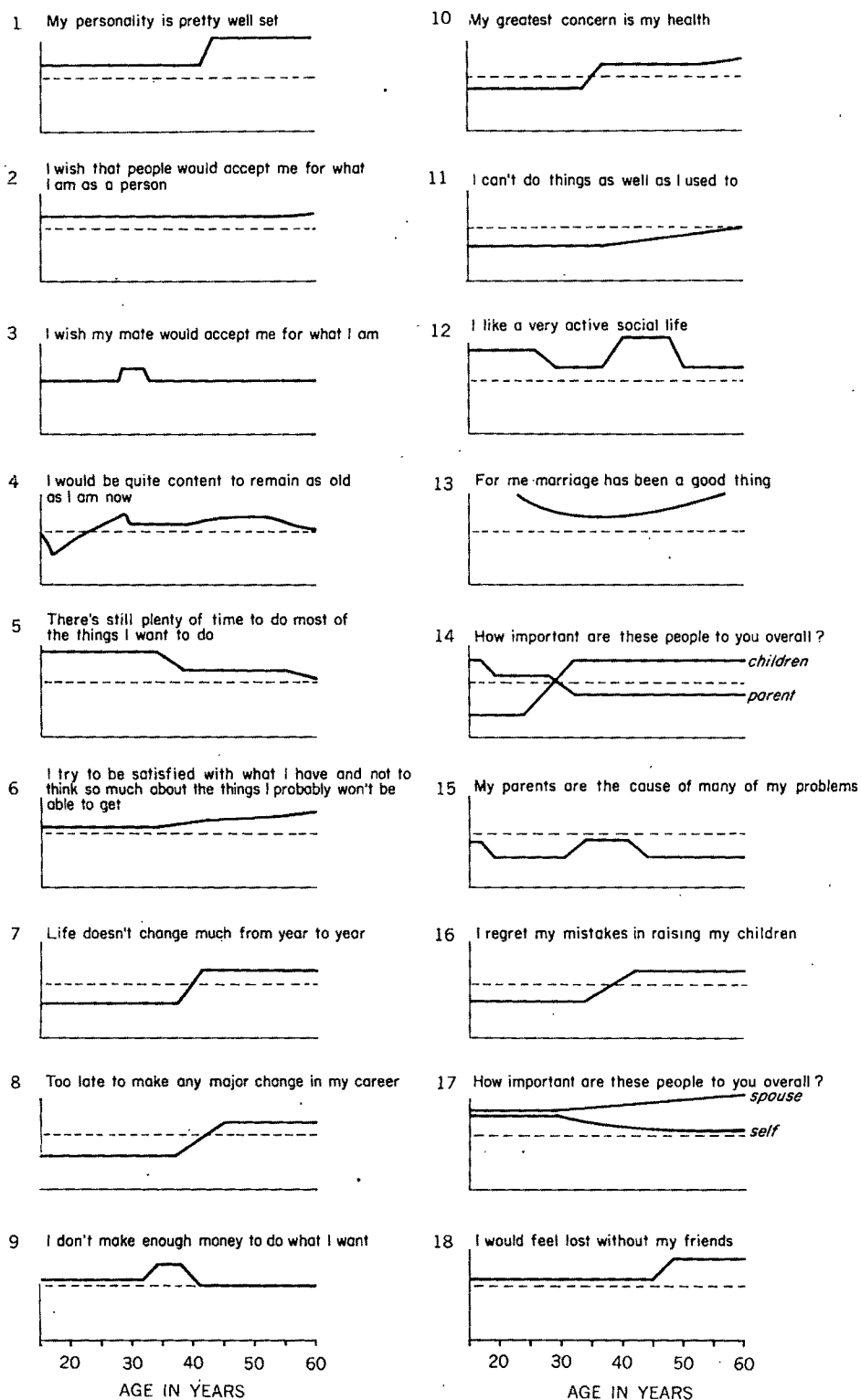
We constructed a questionnaire that could be administered simply to a nonpatient population. The items that composed the questionnaire were salient statements heard in the "phase of life" groups. To avoid overweighing the questionnaire with the clinical bias we developed during the group observations, we enlisted the aid of eight first-year medical students. These students were presented with all of the tape-recordings of the two sets of "phase of life" groups. The students broke up into small groups and listened to the tapes after receiving one simple instruction from me: "List the statements describing personal feelings that stood out during the tape-recorded sessions." A compilation of these statements from all the age groups was then organized into topical sections. The topical section titles were inductively arrived at from the content of the statements. We decided to include only 16 statements in each topical section since we had decided on a forced-choice ranking format.

The titles were not printed on the questionnaire but the eight titled sections were: 1) sense of time; relationships to 2) parents, 3) friends, 4) children, 5) spouses; and feelings about 6) own personality, 7) job, and 8) sex. We added two additional sections that were not empirically determined, sections 9 and 10. In section 9 we asked the subjects to rank order a list of major concerns in life. In section 10 we asked them to rank order the importance of the major people in their everyday life—children, parents, spouse, self, and boss—in regard to each of the following: companionship, approval, decision-making, and general influence. Section 1 of the questionnaire is included here as an example of the wording and type of statements in the questionnaire:

1. I feel that some exciting things are going to happen to me.
2. I never plan on what tomorrow may bring.
3. It hurts me to realize that I will not get some things in life I want.
4. I live for today; forget the past.
5. I think things aren't as good as they used to be.
6. I believe I will some day have everything I want in life.
7. My life doesn't change much from year to year.
8. There is little hope for the future.
9. I try to be satisfied with what I have and not to think so much about the things I probably won't be able to get.
10. I wish I could change the past.
11. I dream about life ten years from now.
12. I spend more time now thinking about the past than about the future.
13. There's still plenty of time to do most of the things I want to do.
14. I would be quite content to remain as old as I am now.
15. I find myself daydreaming about good experiences in the past.
16. I will have to settle for less than I expected, but I still think I will get most things I want.

The questionnaire was then given to a white middle-class educated population of 524 who were selected by two criteria; they were not psychiatric patients and they were available through a network of acquaintances emanating from a core of eight medical students

FIGURE 1
Sample Curves Associated with the Time Boundaries of the Adult Life Span



and several hospital volunteers. Monitoring of the age of the respondent as the questionnaires were returned allowed us to purposively sample ages not represented in the early returns. Our final sample included approximately 20 subjects for each year between 16 and 33 and 20 subjects for each three-year span between 33 and 60. The male-female ratio was approximately 1:1 for the total sample but was unevenly distributed, with women being disproportionately represented over age 45.

Results

Each subject supplied each of the 16 statements in each section with a rank order from one to 16. Curves for each statement were plotted on the basis of the average rank ordering for the 20 subjects at each age. Since there were 142 separate statements composing the questionnaire, there were 142 scores for each age between 16 and 60 and 142 curves were developed from these scores. Each age-point on each curve therefore represents the *average* rank order of 20 same-aged subjects for that statement relative to the other 15 statements in its section.

By putting all of the curves on a single type of graph (using ages 16–60 as the abscissa), we were able to clearly see the unstable periods when response scores changed, i.e., when the greatest number of statements changed rank order (see figure 1). These change periods were interpreted as transitional periods or time zone boundaries. The bulk of the responses stabilized in the period between ages 22 and 29 and remained stable throughout the life span. The stable response curves of this period provide us with a well-established baseline. The responses of the 16- to 17-year-olds were almost identical, except in age-inappropriate areas (children, job security, etc.), to the stable patterns of those aged 22 to 29. In contrast, the 18- to 22-year-olds responded discontinuously. After 29, the rank order of selected statements began to change from the age baseline at two ages, 30 and 37. Most of these late-changing curves stabilized at around age 43. A less impressive but definite series of response fluctuations occurred at the end of the fourth decade. Thus there are suggestions of seven distinct age periods: 16–17, 18–21, 22–28, 29–36, 37–43, 44–50, and 51–60.

In the previous step, we were not interested

in which statements changed rank order, only the number of changes in rank order at a certain time. To begin to look at the content of the statements with changing scores between 16 and 60, we graphed each topical section individually. Since the statements were empirically determined, there was no correct answer and no logical connection that could be applied in rank ordering the section. Therefore, the change in rank for each statement from one year to the next becomes the measure of a type of collective subjective accounting, representing the average “hunches” of 20 subjects at each age. A statement that rings a bell or connects with a feeling of immediacy will rise in rank for that age group and will have to compete with other such statements or consistently popular stereotyped statements.

For the purposes of establishing the time boundaries of the adult life span, those curves with the most rapid and stable changes (and face validity when compared with the bulk of unchanging curves) interest us the most and are presented in figure 1. Several of the curves lend weight to our clinical observation of the groups and add a knowledge of age specificity that we did not have. As can be seen in graph 1, the ranking of the statement “My personality is pretty well set” takes a dramatic jump to a new level between 41 and 43.

In another group observation, we noted that the strong desire to be “accepted for what I am by my spouse” is present in the 28- to 34-year-old group. That statement was present in two forms in the questionnaire under two separate sections: “I wish that people would accept me for what I am as a person” under the friend section, and the more specific “I want to be accepted for what I am by my spouse” under the marital section. The two curves are shown in graphs 2 and 3 and it can be seen that the excursion from the baseline is quite specifically related to spouse and takes place between ages 28 and 32.

In the statement “I am content to remain as old as I am,” there is a gradual continuous rise during the 20s starting from a low at 18–19 until a peak is reached at 29 with a sharp descent in the 30s. This adds weight to our observation that there is a marked subjective experience in the early 30s that life is much more difficult and painful than it appeared in the 20s.

By comparing them with the 20s, we can use these three curves (graphs 2-4) to bracket the 30s with some evidence that a change or opening-up process begins in the 30s and a stabilization and closing-off process begins in the early 40s—around 43 as experienced and reported by our sample. Now let us look more closely at our curves for the 30s, which add weight to the observation that this age period is a time of active psychological change.

We can categorize the curves of the 30s as demonstrative of two major shifts. There is a gradual peeling away of the magical illusions of omnipotence and omnipotentiality and there is an identification of the self with the family.

Under the first category are the curves of graphs 5-11. As can be seen, there are significant changes beginning in the 30s as the sense of time becomes finite while a reconciliation with the limitations of being merely mortal involves work choice, the sense of well-being, money resources, and the deterioration of some general abilities. It is well to note that most of these processes start in the mid-30s and leave the early 30s free of the constricting sense of time that characterizes the late 30s and early 40s in our group observation.

The curves interpreted as part of the process of turning inward toward the family and a blurring of self-definition with the family are as shown in graphs 12-17. There is direct evidence in this series of curves that the preference schedule for involvement switches in the early 30s from the stable patterns of the 20s. There is a turning away from an active social life outside the family to a focus on their own children and a reconsideration of their parents' mistakes with them while they are considering their mistakes with their own children. In addition, there is a drifting downward in the sense of satisfaction in the marriage as compared with the highly valued marriage of the 20s. There is also increased difficulty in making the marriage work and complaints of not being able to communicate with the spouse (graph not shown). Parent, child, self, and spouse are all intimately interrelated and interchangeable by the substitution processes that seem to appear in these graphs.

In the 40s, two things happen to the curves of the questionnaire answers. Between

40 and 43 there is a series of temporary excursions from well-established lifelong baselines on statements dealing with personal comfort, indicating an acutely unstable period with a great deal of personal discomfort. In addition to the return to baseline on these statements at 43, there is a general stabilization and leveling off of the changes started in the early and mid-30s. This coincides with the dramatic affirmation of the feelings that one's personality is pretty well set (graph 1) and that life does not change from year to year (graph 7).

Marital happiness and contentment with the spouse continue to increase, along with a renewed interest in friends and social activities, as seen in graph 18. Friends and social activities are not substitutes for concern with one's own children, which continues at a very high level.

In the 50s the curves indicate that one begins to feel less responsible for one's children and begins to look for the children's approval as a meaningful concern to be ranked as coequal with self-approval and the spouse's approval. The concern with health increases during the 50s. The certainty that time is running out is reflected in several curves, especially graphs 5 and 6.

Discussion and Conclusions

There is a great danger in trying to use cross-sectional data as an aid to our understanding of a continuous process. The difference in responses by age may reflect the sequence of cultural values learned during formative years by different groups rather than a response determined primarily by the age of the responder. The questions with moral implications are most likely to fall in the former category. Most of the changing curves presented in this paper do not fall into the moral, learned response category but are questions related to time sense that are most likely to be age-determined. With these limitations in mind, I think we are on safe ground in considering that the longitudinal process is represented in this sequential series of cross-sectional samples.

Some of the results of our questionnaire study are happily supported by the few independent studies already in the psychological

literature that deal with this subject. In particular, our curves on marital happiness (16), contentment to remain the same age (14, p. 373), anxiety in the 40s in relation to performance (17), a sense of the finiteness of time in the mid-30s (11), reconciliation in the 40s (12), health concerns (13), decreased interest in social activities in the 30s, and increased interest in friends and organizations in the 40s (15) all conform to the results of previous studies using different methodologies and different populations. The correlation of the questionnaire results with these independent studies, and the similarity of the findings of our direct observation of patients to those of the questionnaire study of nonpatients, certainly provide evidence that the adult period is a time of active and systematic change. In addition, there is strong evidence that a series of distinct stages can be demarcated.

The studies reported in this paper have been designed to cancel out individual differences in order to highlight whatever sameness inheres in a group of age-peers. Patients and nonpatients are not discriminable in these studies, but this in no way implies there is no difference between the groups. We looked only at the contents of the subjective experience relative to age, not the intensity of the degree to which this reality of time interacts with other powerful factors in people's lives. Although the results may be considered factual inasmuch as they can be confirmed or negated by other observers, they are not observations pertinent to any one individual but constructs derived from specific groups that may be applicable to other groups.

The results are best thought of as a description of a sequence of process fluctuations that define the posturing of the self to its inner and outer world over time. The fluctuations are time-dominated, but not necessarily age specific for any one individual. In addition, the fluctuations take place within the context of a total personality, life-style, and subculture and each man can be compared only with his own self at a former time. How these shifts are expressed and coped with is a matter of individual psychology beyond the scope of this paper. The subject of this paper has been the manner in which the passage of time influences the actuality of experiences during the adult life span.

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REFERENCES

1. Freud S: Case studies (1893-1895), in Complete Psychological Works, standard ed, vol 2. Translated and edited by Strachey J. London, Hogarth Press, 1955, pp 135-183
2. Freud S: Three essays on sexuality (1901-1905), in Complete Psychological Works, standard ed, vol 7. Translated and edited by Strachey J. London, Hogarth Press, 1955, pp 173-206
3. Erikson E: Growth and crises of the healthy personality. *Psychol Issues* 1:50-100, 1959
4. Benedek T: Parenthood as a developmental phase. *J Amer Psychoanal Ass* 7:389-417, 1959
5. Rangell L: The role of the parent in the oedipus complex. *Bull Menninger Clin* 19:9-15, 1955
6. Jacques E: Death and the mid-life crisis. *Int J Psychoanal* 46:502-514, 1965
7. Bühler C, Massarik F (eds): *The Course of Human Life*. New York, Springer, 1968
8. Neugarten B, et al: *Personality in Middle and Late Life*. New York, Atherton Press, 1964
9. Neugarten B (ed): *Middle Age and Aging*. Chicago, University of Chicago Press, 1968
10. Lehman H: *Age and Achievement*. Princeton, Princeton University Press, 1953
11. Lewin K: Field theory and experiment in social psychology. *Amer J Sociol* 44:868-896, 1939
12. Slotkin JS: Life course in middle life. *Social Forces* 33:171-177, 1952
13. Dykman R, Heimann E, Ken W: Lifetime worry patterns of three diverse adult cultural groups. *J Soc Psychol* 35:91-100, 1952
14. Pressey S, Kuhlén R: *Psychological Development Through the Life Span*. New York, Harper & Row, 1957
15. Strong E: *Change of Interests with Age*. Stanford, Stanford University Press, 1931
16. Terman L: *Psychological Factors in Marriage Happiness*. New York, McGraw-Hill, 1938
17. Welford AT: Age and skill: motor, intellectual and social, in *Decision Making and Age, Interdisciplinary Topics in Gerontology*, vol 4. Edited by Welford AT, Birren JE. New York, Karger, 1969, pp 1-22

Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children

BY L.M. GREENBERG, M.D., M.A. DEEM, PH.D., AND S. McMAHON, M.D.

In an eight-week double-blind study 61 hyperactive school-age boys were randomly assigned to chlorpromazine, dextroamphetamine, hydroxyzine, or placebo groups. Chlorpromazine and dextroamphetamine, virtually equally effective, were significantly more effective than hydroxyzine in modifying hyperactivity. Dextroamphetamine produced frequent side effects; chlorpromazine did not. The authors suggest that because response to the latter two drugs is highly individualized, final selection must depend upon clinical acumen and perhaps a trial of medication.

A RECENT SURVEY by Greenberg and Lipman (1) revealed that pediatricians and child psychiatrists were inconsistent in their treatment of hyperactive children. Although the pharmacotherapy of hyperactive children has been the subject of many clinical and experimental studies for more than 30 years, most of the clinicians surveyed reported that they did not know enough about these

children and psychoactive medication to prescribe medication with confidence. The clinicians were confused by the inconsistent results reported in the literature and experienced in their practices.

The hyperkinetic reaction of childhood is an ill-defined behavior disorder, often of unknown etiology. Although schoolteachers "know" what a hyperactive child is, clinicians and researchers frequently cannot agree. It is only recently that objective measures of activity level have been used by a few researchers (2). However, these developments are of limited clinical significance. Several investigators have questioned the assumption that the child's activity level is the proper "target" symptom (3). Instead, the hyperactivity often appears to be the result of a more basic disturbance of attention that can be caused by many psychiatric, neurologic, pediatric, and psychological processes. More frequently than not, studies of hyperactivity in children focus on particular facets of the problem, such as learning problems or minimal brain dysfunction, rather than on the broader topic. This can be attributed in part to the paucity of multidisciplinary research in this area and to the complexities of the behavior disturbance.

The pediatric psychopharmacotherapy literature contains few rigorously conducted studies of drug effects on behavior; many contradictory and questionable findings are reported (2, 4). Unfortunately, multidrug comparisons are exceedingly rare in this field even though the clinician is in great need of the type of data that can be obtained from such studies. This study was designed to determine the clinical efficacy of three commonly prescribed medications—chlorpromazine, dextroamphetamine, and hydroxyzine—in the treatment of hyperactive children.

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Method

The Sample

The study sample consisted of 76 school-age black boys, most of whom were inner-city residents. The boys, aged six and one-half to 11 years (mean = 8.7 years), were referred by school personnel or by physicians to an outpatient clinic at Children's Hospital of the District of Columbia because of hyperactivity, impulsivity, poor attention span, and poor academic performance. The mean IQ scores on the Wechsler Intelligence Scale for Children (WISC) were: verbal—87, performance—86, and full scale—85. There were no significant differences among the groups in age, IQ, length of drug trial (8.3 weeks), and dropout rate (14.4 percent).

Clinic Routine and Drug Administration

Following referral, a comprehensive evaluation was completed, including social work interviews as well as pediatric, psychiatric, and psychological evaluations. Patients were reviewed in a diagnostic conference, and the staff pediatrician met with parents and child to interpret preliminary diagnostic results. If the child was diagnosed as hyperkinetic, then the eight-week trial on medication, schedule of drug administration, clinic procedures, and possible side effects were also discussed.

Children were randomly assigned to one of four treatment groups using a double-blind technique. The three drugs and placebo were all packaged in unmarked pink number-2 capsules and dispensed at the hospital pharmacy. The medication was prescribed by the number of capsules administered in the morning with breakfast and at midafternoon. Each capsule contained 25 mg. of chlorpromazine, 5 mg. of dextroamphetamine, 25 mg. of hydroxyzine, or placebo. The number of capsules was gradually increased except when the presence of side effects necessitated a lower dose. During the fourth to eighth weeks an average of 125 mg. of chlorpromazine, 25 mg. of dextroamphetamine, and 150 mg. of hydroxyzine were administered daily. At the eighth week the comprehensive evaluation was repeated and a final diagnostic staff meeting was held.

Assessments

We assessed the following items: incidence of side effects; a psychiatric rating based on

clinical interviews; a comprehensive psychological evaluation including WISC, Porteus Maze Test, figure drawings, and Bender-Gestalt; behavior ratings of hyperactivity by mother, teacher, and each clinician (based on the Schaefer-Aaronson Scales [5]); and clinical judgments of improvement by the mother and each clinician. The psychiatric rating scale was composed of inferential statements about the child and his behavior including intensity and frequency of motor restlessness, attention span, emotional lability, self-control, cooperation, relationship, depression and anxiety levels, content and prevalence of fantasies, and characterization of thinking processes. Clinical judgments were based on the information available to each judge and were divided into five categories ranging from "worse" to "very improved." More detailed data analyses of some of these measures (particularly the behavior ratings and psychological tests) are planned for later publications.

Results

Side Effects

The chlorpromazine group reported sleepiness and increased appetite significantly more often than did any of the other children (table 1). Children receiving dextroamphetamine complained of decreased appetite and had stomachaches more often than did the hydroxyzine- and placebo-treated children. Two of the children receiving dextroamphetamine manifested marked regressive, dependent behavior. One subject receiving dextroamphetamine (10 mg. per day) became overtly psychotic. The intensity of all of the side effects improved with a decrease in dosage.

Significant changes in weight occurred, as demonstrated by analysis of covariance. As might be expected, a period effect on weight was noted for all groups; however, drug effects were also significant. The chlorpromazine group gained weight, with a maximum gain of 11 pounds. The dextroamphetamine group lost weight, with a maximum loss of seven pounds. (Maximum placebo gain and loss were seven pounds and one pound, respectively.) Table 2 presents the percentage of children who lost or gained weight and the mean weight changes for each group. The difference in weight change between the

TABLE 1
Percentage of Subjects Reporting Side Effects

SIDE EFFECT	PLACEBO (N = 10)	CHLORPROMAZINE (N = 17)	DEXTROAMPHETAMINE (N = 17)	HYDROXYZINE (N = 17)
Sleepiness	30	82*	35	16
Increased appetite	10	76*	16	29
Decreased appetite	20	16	76*	35
Insomnia	10	12	53*	16
Increased depression	10	16	49*	12
Irritability	0	12	29*	6
Dizziness	0	23	23	16
Headache	10	23	41**	16
Stomachache	0	23***	41†	0
Psychosis	0	0	6	0

*Greater than the other three groups, using $p < .10$ as the level of statistical significance.

**Greater than placebo, using $p < .10$ as the level of statistical significance.

***Greater than hydroxyzine, using $p < .10$ as the level of statistical significance.

†Greater than hydroxyzine and placebo, using $p < .10$ as the level of statistical significance.

chlorpromazine and dextroamphetamine groups is significant at the .05 level (Scheffe test).

Dosage Level

When the subjects who reached and maintained maximum dosage were examined, differences among the treatment groups became evident (table 3). All of the subjects in the hydroxyzine group attained maximum dosage (150 mg. per day), while less than half of the subjects receiving dextroamphetamine or chlorpromazine reached this goal. Approximately half of the dextroamphetamine group were kept on a low dose, on which they seemed to benefit without the side effects encountered in higher dosage levels. Nearly one-fourth of those who reached the maximum dose of chlorpromazine at four weeks were later reduced to a lower dose because of side effects. The mean number of capsules per day at eight weeks was as follows: placebo—5; chlorpromazine—5; dextroamphetamine—5; and hydroxyzine—6.

Psychiatry

Comparisons of the pretreatment and posttreatment psychiatric ratings indicate that the dextroamphetamine-treated children

improved in self-control with reference to the placebo group ($p < .10$). While the other changes are not statistically significant, they represent trends that suggest hypotheses for further studies of drug effects. Chlorpromazine treatment appeared to be associated with increased motor restlessness, improvement in the organization of thought processes, and reductions in the prevalence of fantasies and level of depression. Dextroamphetamine was associated with decreased anxiety and either increased or decreased (bimodal distribution) motor restlessness, level of depression, and severity of psychiatric diagnosis. Hydroxyzine treatment was associated with increased motor restlessness and improvements in the level of anxiety and severity of psychiatric diagnosis.

Psychology

Results for the WISC performance scale, the Porteus Maze Test, the figure drawings, and the Bender-Gestalt appear in table 4, which presents the adjusted mean scores at the eighth week from the analysis of covariance. The mean posttreatment performance IQ for the dextroamphetamine group was significantly greater than the mean for the placebo group ($p < .05$, Dunnett's test),

TABLE 2
Weight Changes

DRUG GROUP	NUMBER*	PERCENTAGE SHOWING CHANGE		MEAN CHANGE (POUNDS)	
		INCREASE	DECREASE	INCREASE	DECREASE
Placebo	9	77	10	2.8	1.0
Chlorpromazine	14	93	0	3.9	0
Dextroamphetamine	15	13	73	0.66	3.2
Hydroxyzine	15	66	7	2.0	1.0

*Data available for subjects who made all four visits.

TABLE 3
Characteristics of Drug Administration

DRUG ADMINISTRATION	PLACEBO (N = 10)	CHLORPROMAZINE (N = 17)	DEXTROAMPHETAMINE (N = 17)	HYDROXYZINE (N = 16)
Maximum dose at four weeks	8	9	5	13
Maximum dose at eight weeks	7	6	8	16
Consistently low dose	2	7	7	0

whereas the means for the chlorpromazine and hydroxyzine groups were not. For the Porteus data, analysis of covariance revealed significant differences among the four drug groups ($p < .05$). The Newman-Keuls test indicated that the dextroamphetamine group had significantly greater Porteus IQs than either the placebo- or chlorpromazine-treated children ($p < .05$). Although the results for each of the medication groups were better than those for the placebo group on the figure drawing and Bender tests, none of these results was statistically significant.

Behavior Ratings

Analysis of the hyperactivity ratings indicates significant drug effects for home and pediatric ratings, but not for teacher, psychiatric, and psychological ratings. Results of the home behavior ratings indicate consistently decreasing hyperactivity scores for all treatment groups between the fourth and eighth weeks on medication. In addition, these ratings of hyperactivity discriminated among the four treatment groups ($p < .01$). Children receiving chlorpromazine or dextroamphetamine demonstrated the greatest reduction in hyperactivity at the completion of the drug trial. Both groups had significantly lower hyperactivity scores than did the placebo group ($p < .05$, Newman-Keuls test), but there were no differences between the chlorpromazine and dextroamphetamine groups. The mean score for the hydroxyzine group was greater than that for the placebo group and less than the means for the other treatment groups, but it was not significantly

different from each. Results for the pediatric ratings of hyperactivity followed patterns similar to those of the mothers.

Clinical Judgments

Analysis of variance tests determined significant differences among treatment groups for pediatric, psychological, and total staff ratings of clinical improvement. Scheffe tests (table 5) indicated that the dextroamphetamine-treated children received significantly higher ratings of improvement than children receiving placebo by the pediatrician ($p < .05$), psychologist ($p < .05$), and total staff ($p < .10$). Only the pediatrician rated another medication, hydroxyzine, as producing significantly more improvement than placebo ($p < .05$).

Discussion

Side Effects

The selection of appropriate treatment for any disorder is influenced by ease of administration and probability of adverse effects. These must be weighed against desired effects. All of the active medications used in this study were associated with side effects to a far greater extent than was placebo. Yet only chlorpromazine and dextroamphetamine demonstrated significant differences in the number of side effects when each was compared to the other treatment groups. The low incidence of side effects with hydroxyzine is consistent with findings in a previous report (6), although drowsiness and dry mouth might have been expected as frequent complaints.

TABLE 4
Adjusted Mean Scores at Week Eight on Selected Tests

TEST	PLACEBO	CHLORPROMAZINE	DEXTROAMPHETAMINE	HYDROXYZINE
Performance IQ (WISC)	88.0	92.7	96.2*	91.4
Porteus IQ	96.9	98.6	111.5**	103.6
Figure drawing IQ	89.2	92.1	93.9	93.3
Bender-Gestalt (Koppitz errors)	9.2	7.1	7.7	7.1

*Greater than placebo; $p < .05$.

**Greater than placebo and chlorpromazine; $p < .05$.

TABLE 5
Mean Judgments of Improvement by Staff

JUDGE	PLACEBO	CHLORPROMAZINE	DEXTROAMPHETAMINE	HYDROXYZINE
Pediatrician	2.30	3.24	4.18*	3.71*
Psychiatrist	3.30	3.00	2.59	3.18
Psychologist	2.60	2.56	3.88*	2.59
Total staff	2.20	3.06	3.13**	2.94

*Significantly different from placebo (Scheffe tests); $p < .05$.

**Significantly different from placebo (Scheffe tests); $p < .10$.

The findings in this study are consistent with reports of increased sleepiness, appetite, and weight, which have been commonly associated with administration of chlorpromazine. In addition, symptoms of gastrointestinal disturbances were encountered. Since chlorpromazine is known to block alpha sympathetic functions, it is interesting to note that no significant change took place in blood pressure. (Systolic and diastolic pressures were analyzed separately.) There were no cases of agranulocytosis (7) or changes in liver function during the eight weeks of treatment. None of the children experienced the rare complications of urinary retention, edema, or extrapyramidal symptoms (8). Chlorpromazine did not produce a greater incidence of depression than placebo or hydroxyzine.

The dextroamphetamine group experienced a significant number of most of the expected side effects (anorexia, weight loss, insomnia, headache, and stomachache), but tachycardia and hypertension did not occur significantly more often than with placebo (9). The improvement of the child with dextroamphetamine-induced psychosis upon withdrawal of medication is similar to that of a case reported by Ney (10). The patient's history will be reported in detail elsewhere. The incidence of this serious complication may not be so small as was once thought.

An unexpected finding was increased depression in children treated with dextroamphetamine. It had been expected that dextroamphetamine would function as a mood elevator. There are several possible explanations for the increase. Psychotherapists have long been aware of the phenomenon of acting out. As long as the individual is able to discharge intrapsychic conflicts through direct action, there is little opportunity for the conflict itself to be perceived by the individual. The behavior (acting out) is the designated problem, and the intrapsychic conflicts are

not recognized. When chemical agents are administered, dramatic changes in long-standing behavioral patterns are effected. Intrapsychic conflict would then become inescapable, resulting in increased depression. The child is now face-to-face with his conflict. In addition, the sudden change in behavioral patterns will arouse considerable anxiety and depression as the child struggles to obtain better control of his impulses and conflicts.

Barcai (11) has suggested that altered interpersonal patterns of behavior were the major source of "neurosis" or depression in these children. There is no doubt that the suddenly altered behavior stresses the environment. The child's changed behavior does conflict with the expectations of authority figures and meaningful others—parents, siblings, peers, and teachers. In the ensuing struggle to redefine the situation, the child, confused by the mixed messages and changing field, becomes increasingly frustrated and depressed. However, this confusion is probably not the primary cause of neurotic or depressive symptoms. Rather, the neurotic conflicts are the antecedents that become more apparent when the behavior is altered.

The hypothesis that depression is the causal factor leading to hyperactivity has also been suggested. The models frequently cited are the agitated depressive and the manic-depressive. These models may hold for a small number of hyperactive children. However, there is no evidence to support the theory that depression precedes the behavioral disturbance. In fact, there is much clinical evidence that refutes this hypothesis. Many hyperactive children become less depressed when able to concentrate and therefore cope with their problems more successfully.

One final explanation is relevant. The pediatrician, who saw the children frequently during the study, reported that they appeared more depressed during their last clinic visit than in previous ones. These children enjoyed

their clinic visits and looked forward to them. The clinic was the one place where they experienced acceptance, understanding, and gratification of their dependency needs. It would not be surprising, then, to observe the increase in depression in children faced with the threat of an imminent separation.

Dosage Level

It appeared that the dosage level attained was inversely related to the incidence of side effects. Thus hydroxyzine dosages were maintained at maximum levels (150 mg. per day) with relatively few side effects. This observation may help to explain the pattern of administration of medication to hyperactive children reported by Greenberg and Lipmar (1). They noted that over one-fourth of the pediatricians surveyed prescribed hydroxyzine, although they reported that the psychostimulants were drugs of choice.

Psychiatry

The tendency toward bimodal responses with dextroamphetamine treatment has been reported by others (12). Children tend to show either dramatic improvement or equally dramatic deterioration with this medication. Preliminary studies reported by Satterfield and associates (13) suggest that two subgroups of hyperactivity exist, as defined by psychophysiological tests. Children who improved during psychostimulant therapy were characterized by a lower central nervous system (CNS) arousal level prior to treatment. The children who did not improve with psychostimulant treatment appeared to be characterized by higher CNS arousal levels prior to treatment. Our clinical observations appear to support these findings, and an additional study is being conducted at the present time (14).

Psychology

Previous research with children has studied the effects of chlorpromazine, dextroamphetamine, and methylphenidate on a number of psychological tests (15-18). In contrast to chlorpromazine, the psychostimulants have consistently been associated with improved functioning, particularly on the performance scale of the WISC and on the Porteus Maze Test. Results from the present study, which also included a minor tran-

quilizer, indicated that all three active medications tended to have a more favorable effect on psychological measures than did placebo.

Dextroamphetamine was the most consistent in showing the selective and positive effect on test performance, enhancing function on the performance scale of the WISC and on the Porteus Maze Test. Improved performance on these tasks has usually been explained as the result of increased attention and/or increased cortical control. For example, the Porteus Maze Test has been accepted as a measure of control and inhibition (19). Two other possible explanations, changes in motivation and motor control, are less likely. If motivation were affected, one would anticipate a generalized impact on performance. However, stimulants seem to affect tasks selectively. The paucity of positive findings with measures of motor coordination appears to disprove the postulated motor control changes. For example, the stimulants have had no effect on scores on the Bender-Gestalt (12, 17, 20). Furthermore, Knights and Hinton (18) found that methylphenidate did not affect the Bender-Gestalt scores or two separate measures of motor steadiness.

Contrary to expectation, when chlorpromazine was administered to hyperactive children in therapeutic dosages it did not adversely affect cognitive and motor functioning. Therapeutic use of chlorpromazine in adults has usually resulted in intellectual deterioration (21). Helper and associates (22) reported that chlorpromazine had a negative influence on children's performance on the Porteus Maze Test and on paired-associate learning tasks. Werry and associates (15), however, compared the effects of chlorpromazine and placebo and found no significant differences on subjects' performance on 32 subtests of psychological measures. The finding that chlorpromazine can reduce hyperactivity (as judged by mothers and pediatricians) without impairing performance or learning is meaningful in terms of clinical application.

Hydroxyzine did not affect performance on the test battery. Because of the absence of findings on psychological measures, it was concluded that hydroxyzine served as an active placebo at least with reference to test performance.

Behavior Ratings

The reactive nature of hyperactivity and the situational determinants of activity level have been discussed in detail by others (23). It has been shown that activity in children can vary from day to day, situation to situation, or from time to time within the same situation. It would not be surprising, then, to find that changes in hyperactivity vary from classroom to home to clinic. The findings of others do, in fact, support the hypothesis of differential drug effects depending on the situation observed, the raters employed, and the specific scale used.

The Werry-Weiss-Peters Scale (24) has been used to measure the effects of chlorpromazine, dextroamphetamine, and methylphenidate on home behavior (12, 19, 25). Others have successfully used the same scale to show effects of the stimulants on behavior as perceived by parents (16, 18). In the present study, equivalent sets of behavior rating scales were used to evaluate the effects of drugs on hyperactivity at school, home, and in the clinic. The statistically significant decrease in hyperactivity as measured by mothers' ratings of home behavior was consistent with the results of the pediatric ratings of behavior. This result is noteworthy when one considers the dissimilarity in the situations. However, not only were the mothers present during the pediatric examinations, but their weekly reports may have influenced the pediatric ratings. Studies are planned to further develop the clinical ratings of behavior as clinical tools.

Clinical Judgments

The pediatrician rated the dextroamphetamine and hydroxyzine groups as significantly more improved than the placebo group. The chlorpromazine group, although not significantly different from the placebo group, tended to approach the dextroamphetamine and hydroxyzine groups in improvement. These judgments were based on clinical change and information from the patient, who was biased by the incidence of side effects.

The psychologists' significantly higher rating of dextroamphetamine, in comparison to placebo, reflects the differences in pretreatment and posttreatment performance of the children.

Total staff judgments were based on clinical

change as reported by all sources of data and on the incidence of side effects. Dextroamphetamine was again judged to be significantly better than placebo in spite of the high incidence of side effects.

The children preferred dextroamphetamine least of all. This finding is noteworthy, however, in view of the concerns about the possible euphoric (and potentially addicting) effects of dextroamphetamine in hyperactive children (26). None of the subjects reported euphoric effects. Instead, many of them complained about the medication. Even some of the children who recognized considerable improvement in their thinking and behavior did not like dextroamphetamine. They complained particularly of being more irritable, tearful, and easily upset. The occurrence of these side effects seemed to be the major factor in determining the children's judgment of drug efficacy.

The judgments of improvement by professionals and patients in this study appeared to be influenced by the following factors: the amount of data available to the judge; the type of data; the particular settings and situations involved in obtaining the data; the judge's criteria of improvement; the role of the judge, observer, or participant; and the attitudes and experiences of the clinicians, parents, and children with previous drug treatment, as well as a number of other nonspecific factors. Two of these factors merit comment. The type of data available to the researcher is usually cross-sectional in nature. Unlike the mother, teacher, and pediatrician, the researcher seldom observes the subject longitudinally. Unfortunately, the researcher, by designing the short-term study with little opportunity for repeated measures, restricts the clinical value of the research.

In pharmacotherapy research, it is of considerable importance to explicitly state not only the data upon which clinical judgments are based, but also the criteria used. As illustrated in the present study, conclusions about a medication's usefulness are dependent on the criteria selected to assess clinical change. At this time in pharmacotherapy research, the establishment of standards for improvement remains a critical unsolved need.

Conclusions

Chlorpromazine. Chlorpromazine was

moderately effective in modifying hyperactive behavior, with almost no serious side effects. The absence of adverse effects is striking in view of past reports of detrimental effects on test performance.

Dextroamphetamine. Dextroamphetamine was associated with both strongly favorable and strongly unfavorable observations, although fewer of the latter. The frequent physical and psychiatric side effects necessitated many dosage manipulations.

Hydroxyzine. Hydroxyzine was associated with few favorable or unfavorable effects.

The determination of whether dextroamphetamine or chlorpromazine is preferable for an individual's treatment remains problematic. Predictors of improvement with either medication have not been delineated, and response is highly individualized as we know it now. The final selection must still depend upon clinical acumen and, perhaps, a trial of medication. It is felt that the physician evaluating the progress of his patients during treatment may well rely upon the mother's reports, as well as on his own clinical judgment. In addition, for longitudinal information, it may be useful to employ behavior ratings by mother, teacher, and pediatrician.

REFERENCES

- Greenberg LM, Lipman RS: Pharmacotherapy of hyperactive children: current treatment practices. *Clin Proc Child Hosp DC* 27:101-105, 1971
- Sprague R, Werry JS, Davis KV: Psychotropic drug effects on learning and activities in children. Presented at the Gatlinburg Conference on Research and Theory in Mental Retardation, Gatlinburg, Tenn, 1969
- McMahon S, Deem MA, Greenberg LM: The hyperactive child. *Clin Proc Child Hosp DC* 26:295-316, 1970
- Fish B: Methodology in child psychopharmacology, in *Psychopharmacology: A Review of Progress, 1957-1967*. Edited by Efron D. Public Health Service Publication no 1836. Washington, DC, US Government Printing Office, 1968, pp 989-1001
- Schaefer ES, Droppelman LF, Kalverboer AF: Development of a classroom behavior check list and factor analyses of children's school behavior in the US and the Netherlands (unpublished paper)
- Dougan HT: Hydroxyzine syrup (Atarax) in the management of pediatric behavior problems. *Med Times* 90:551-554, 1962
- Baldwin RL, Peters JE: Hematologic complications from tranquilizers in children. *Southern Med J* 61:1072-1075, 1968
- DiMascio A, Soltys J, Shader RI: Psychotropic drug side effects in children, in *Psychotropic Drug Side Effects*. Edited by Shader RI, DiMascio A. Baltimore, Md, Williams & Wilkins Co, 1970, pp 235-260
- Grant GR: Psychopharmacology in childhood emotional and mental disorders. *J Pediatr* 61:626-637, 1962
- Ney PG: Psychosis in a child associated with amphetamine administration. *Canad Med Ass J* 97:1026-1029, 1967
- Barcai A: The emergence of neurotic conflict in some children after successful administration of dextroamphetamine. *J Child Psychol Psychiat* 10:269-276, 1969
- Weiss G, Werry J, Minde K, et al: Studies on the hyperactive child: V. The effects of dextroamphetamine and chlorpromazine on behavior and intellectual functioning. *J Child Psychol Psychiat* 9:145-156, 1968
- Satterfield JH, Cantwell DP, Lesser LI, et al: Physiological studies of the hyperkinetic child: I. *Amer J Psychiat* 128:1418-1424, 1972
- Greenberg LM: Discussion of Satterfield JH, Cantwell DP, Lesser LI, et al: Physiological studies of the hyperkinetic child: I. *Ibid*, p 1424
- Werry JS, Weiss G, Douglas V, et al: Studies on the hyperactive child: III. The effect of chlorpromazine upon behavior and learning ability. *J Amer Acad Child Psychiat* 5:292-312, 1966
- Conners CK, Rothschild GH: Drugs and learning in children, in *Learning Disorders*, vol 3. Edited by Hellmuth J. Seattle, Wash, Special Child Publications, 1968, pp 191-224
- Millichap JG, Aymat F, Sturgis LH, et al: Hyperkinetic behavior and learning disorders: III. Battery of neuropsychological tests in controlled trial of methylphenidate. *Amer J Dis Child* 116:235-244, 1968
- Knights RM, Hinton GG: The effects of methylphenidate (Ritalin) on the motor skills and behavior of children with learning problems. *J Nerv Ment Dis* 148:643-653, 1969
- Porteus SD: New applications of the Porteus Maze Test. *Percept Motor Skills* 26:787-798, 1968
- Alexandris A, Lundell F: Effect of thioridazine, amphetamine and placebo on the hyperkinetic syndrome and cognitive area in mentally retarded children. *Canad Med Ass J* 98:92-96, 1968
- Hartlage LC: Effects of chlorpromazine on learning. *Psychol Bull* 64:235-245, 1965
- Helper M, Wilcott RC, Garfield SL: Effects of chlorpromazine on learning and related processes in emotionally disturbed children. *J Consult Psychol* 27:1-9, 1963
- Werry JS, Sprague RL: Hyperactivity, in *Symptoms of Psychopathology*. Edited by Costello CG. New York, John Wiley & Sons, 1970, pp 397-417
- Werry JS: Developmental hyperactivity. *Pediatr Clin N Amer* 15:581-599, 1968
- Weiss G, Minde K, Werry J, et al: Studies on the hyperactive child: VIII. Five-year follow-up. *Arch Gen Psychiat* 24:409-414, 1971
- Federal involvement in the use of behavior modification drugs on grammar school children, of the right to privacy inquiry, in *Congressional Record* 52-268. Washington, DC, US Government Printing Office, 1970

The Effect of Third-Party Payment on the Practice of Psychotherapy

BY PAUL CHODOFF, M.D.

Many issues are raised by the use of third-party mechanisms such as health insurance to pay for psychotherapeutic services. These include such questions as confidentiality, diagnostic and reporting practices, the medical versus the nonmedical model, and transference-countertransference relationships. The role of peer review and other quality control mechanisms will undoubtedly increase as psychiatry is asked to document more fully than in the past the criteria for various forms of psychotherapy and to demonstrate their effectiveness.

A RECENT ISSUE of the *Journal of the American Medical Association* (1) contained a letter from a psychiatrist asking for guidance about a sticky situation with which he had been confronted. He was treating the mistress of a married man who asked the psychiatrist to make out the bill in his name as if he were the patient. It had occurred to the psychiatrist that the married man's purpose was not only to keep the relationship secret but also to collect insurance payment for the services. What, dear editor, the psychiatrist prayed, was his duty in the face of this thorny ethical and legal conundrum?

This tidbit illustrates that when we accept the participation of an otherwise uninvolved third party in the financial aspects of the psychotherapeutic contract, we have come very far from the simple and uncomplicated situation in which the purveyor of the psychotherapeutic services is paid directly either by the recipient of those services or by someone, usually a relative, who has a personal

interest in and responsibility for the patient or client.

However, the issues raised by the increasing use of impersonal third-party payment mechanisms such as health insurance for psychotherapeutic services far transcend in scope and importance the doctor's dilemma described above. In those areas of the country in which this method of payment has become a significant factor in the financial transactions between the two parties involved in psychotherapy, a host of unexpected problems has appeared, either as a direct result of the new mode of payment or because problems previously dormant or glossed over have begun to surface with an urgency demanding answers in terms of dollars and cents rather than theories.

To suggest the range of these problems, I could mention that third-party payment has brought into question such issues as confidentiality, the therapist's allegiance, diagnostic and reporting practices, and transference-countertransference relationships in the therapy. Professional identity confusions appear as the therapist becomes less a priest and more a businessman and the organizations to which he belongs become involved increasingly with guild and political concerns rather than with purely professional ones. Ultimately the third-party interest raises questions about the applicability of the medical model to psychotherapy.

Third-party payment, of course, occurs not only in the private practice of psychotherapy but also when psychiatric care, including psychotherapy, is provided in state and federal hospitals and in outpatient psychiatric clinics and community mental health centers funded by various means. However, in this discussion I shall confine myself to the setting with which I am most familiar—that is, the office practice of private psychotherapy—and I will draw to a considerable extent on the

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experiences of myself and my colleagues in the Washington, D.C., area, where the Federal Employees Health Benefits Program has provided a substantial portion of the income of psychiatrists treating government employees and their families.

Medical Versus Nonmedical Model

For the federal employee in the Washington area whose major medical insurance coverage provides 80 percent payment for outpatient psychotherapy, the third-party influence may first be felt at the point when a prospective patient seeks a therapist. Of course in those cases in which he is referred to or seeks out a physician specializing in psychiatry, the problem I will delineate does not arise. But the potential patient may instead be considering treatment with a nonphysician, such as a psychologist. If he is paying for the services out of his own pocket he can choose between the psychiatrist and psychologist on the basis of what he knows about the kinds of services these two disciplines provide and his feeling about the particular individual. However, if the insurance carrier is paying a substantial portion of the fee, there will usually be an advantage in choosing the psychiatrist instead of the psychologist since the former will be treated by the insurance carrier like any other doctor and will receive his payments accordingly, as long as he lives up to certain requirements. The psychologist, however, is not an M.D. and he will therefore be in a somewhat ambiguous and unclear position as a potential recipient of payment for medical services. If the patient is insured by the largest local carrier, the Blue Cross and Blue Shield plan covering federal employees, the psychologist therapist will have to submit himself either nominally or substantially to the supervision of a psychiatrist physician before his services become eligible for insurance payment; this will affect both his self-image and his relationship with the patient.

The magnetism of financial advantage inherent in this situation will have a differing effect on psychiatrists and on nonmedical psychotherapists. The former group includes a substantial number who in the past have not been reluctant to emphasize the ways in which they are dissimilar from other physicians. Such attitudes are likely to be reversed

as psychiatrists respond to the economic spur of third-party payment, prodding them to mend their medical fences and reestablish their allegiance to the medical model; this obscures some of the real problems about its applicability to their psychotherapeutic practices. The nonmedical therapist, on the other hand, may find himself on the horns of a dilemma since, although his heart may be with the behavioral change model, his pocketbook may push him toward at least grudging acceptance of the medical model. That is, in order to fall within the purview of medical insurance, he will have to acknowledge that he is treating disease rather than charging behavior.

He may choose the alternative of seeking a basic change in the criteria used by the insurance companies, that is, to try to convince them that psychotherapeutic treatment by psychologists should be accepted as parallel and equal to that by psychiatrists (2). This course, which is being pursued by the American Psychological Association, raises very fundamental questions about the use of medical insurance for purposes that could be considered nonmedical and may also tend to widen the breach between medical and nonmedical psychotherapists, already illustrated by the recent conflicts within major psychoanalytic organizations about the admission of certain non-M.D.s as full-fledged members. Although real and substantive differences are involved in this dispute there also appears to be a hidden agenda present in the form of economic guild issues, one of which is the fate of psychoanalysis under present insurance plans and, even more, under a future national health insurance program.

Confidentiality

Let us assume now that the therapist has been selected and that he is a physician. The contract between patient and physician must now include provisions for complying with certain requirements of the third-party insurance carrier. With the approval and knowledge of the patient, some facts about the patient will have to be conveyed to the insurance company by the psychiatrist. But if this requirement is complied with, what about the ideal of absolute confidentiality in the psychiatrist-patient relationship? This is an emotionally laden area for many psychia-

trists, inducing a great deal of anxiety and resentment and, along with this, certain defensive maneuvers. Some psychiatrists, choosing to disregard the axiom that he who pays the piper calls the tune, may go so far as to deny that the insurance company has the right to any information about the patient for whose treatment it is authorizing payment; these psychiatrists may then engage in conflicts or obfuscating maneuvers with the carrier.

Even though the majority of psychiatrists recognize the legitimate need of the insurance carrier to have certain facts about the cases for which they are authorizing payment, they may be troubled by this requirement and by its possible effect in breaching the trust the patient must have that he can say anything at all to his therapist without fear of disclosure. To obviate this uneasiness, psychiatric organizations in the Washington area have worked with the insurance carriers to define and keep to a minimum the information the carriers require to carry out their obligation to their policy holders and to ensure that such information remains only in authorized hands.

But the uneasiness among psychiatrists, justified or not, remains. One of the ways in which it is manifested is in the diagnostic reporting of the condition for which the patient is being treated. Although I have no data on this matter, it is my impression that the most common diagnoses submitted on insurance company forms are anxiety neurosis and depressive neurosis; such *DSM-II* (3) diagnoses as alcoholism, schizophrenia, and homosexuality are made so infrequently as to suggest that patients suffering from these conditions may be receiving other diagnoses.

If this kind of mislabeling is occurring, two sets of reasons could be advanced for it, both at least partially the result of the influence of third-party payment. The first (already mentioned) is the psychiatrist's uneasiness about the confidentiality of the information he is transmitting to an impersonal bureaucracy, where leakage cannot be ruled out; this leakage, including the diagnoses I have just mentioned, may be harmful to the interests of the patients under his care. In this case, incidentally, there is no doubt that the psychiatrist's allegiance is to his patient rather than to the insurance company, so that conflicts about whose interest he is representing would

not arise as they might in other instances of third-party payment such as the military service, where a psychiatrist might have a real conflict between his allegiance to his patient and to the military organization of which he is a member.

But fears that confidentiality may be breached are not the only reason for the diagnostic reporting practices I have suggested. A second factor is the difficulty in conforming some patients to the diagnostic scheme of *DSM-II* (3). This is not a problem in the case of all or even most psychiatric patients receiving psychotherapy; most fall quite comfortably into medically oriented diagnostic rubrics, whether or not the psychiatrist chooses to employ them. However, especially among patients who are being treated by intensive psychotherapeutic (including psychoanalytic) techniques, there are a certain number whose problems, although real, cannot be adequately described in medically oriented diagnostic terms. These are the people whose difficulties in such interpersonal areas as family, work, and social relationships result in relatively little disability in the ordinary medical use of this term. When such individuals pay for their own psychotherapy, the troublesome question of whether they conform to the medical definition of a "patient" need not be a matter of concern to themselves or to their therapists. If the need and the suffering are sufficient, treatment will be undertaken regardless of diagnosis or of whether the sufferer is a "patient." However, medical insurance requires medical diagnoses, and unless this requirement is altered for certain categories of patients seeking psychotherapy, the psychiatric profession is under the increasing necessity of somehow coming to terms with the problem of diagnosis.

Effect on Treatment Pattern

Having agreed to undertake a psychotherapeutic enterprise together, the two parties involved must now also agree on the frequency of visits, a decision that is of major importance in determining whether the psychotherapy will be at the supportive end or the more intensive, psychoanalytically oriented end of the spectrum of possible approaches. When substantial third-party financial assistance is available, this choice

becomes relatively free of financial hindrances so that it may be dictated more by the therapist's judgment about what would be best in this particular case than by the patient's means. Such a payment arrangement provides an opportunity for individuals otherwise not able to afford it to receive skilled and experienced psychotherapeutic help.

However, although substantial help in paying for psychotherapy is clearly beneficial in allowing a freer choice of treatment modality, there may be other consequences. For instance, the absence of clear-cut indications for various types of psychotherapy might influence therapists to choose the kind of therapy they prefer to do rather than to make a decision on the basis of more objective criteria; an increase in the more intensive types of treatment might well result. This danger is not unique to psychiatry; it has been pointed out as a general trend in medicine that the existence of third-party payment provides "little incentive for efficiency. Instead, the trend is to use the higher cost facilities and services and to make as many of these available as possible" (4). On the other hand, it is likely that one of the factors stimulating the present popularity of the various varieties of group therapy is the availability of insurance payment.

It is also clear that as long as there is a discrepancy in the amount of insurance coverage in different geographical areas, more psychotherapeutic services will be dispensed where insurance coverage is substantial. For example, in the Washington, D.C., area the organization previously known as the Baltimore Psychoanalytic Society has changed its name to the Baltimore-D.C. Psychoanalytic Society, since more of its activities are taking place in Washington than in Baltimore, where insurance coverage of mental disorders is much less extensive. Such a differential will tend to disappear once the uniform provisions of a national health insurance program have been agreed upon and implemented; the effect of third-party payment on the choice of psychotherapeutic modalities will then be determined by the amount of coverage for outpatient psychotherapy contained in such a program.

I will now turn to the effect of third-party payment on the course of the psychotherapy itself, that is, its influence on such treatment

dynamics as transference-countertransference issues, resistances, fantasies, defense, motivations for treatment, etc. This subject, which merges with the general effect of payment on psychotherapeutic transactions, although rich in its implications for psychotherapy, has to the best of my knowledge not been sufficiently treated in the relevant literature. Such discussions of the subject as exist are found mainly in regard to intensive psychotherapies, and especially psychoanalysis, since it is in these forms of therapy where a scrutiny of the relationship between therapist and patient is of such importance that these issues find their fullest play and are most likely to be affected by financial transactions.

The Issue of Financial Sacrifice

As far as psychoanalytic psychotherapy is concerned, the paramount question posed by the increasing availability of third-party payment is whether and to what extent such treatments are crippled when regular, direct payments are not made by the patient to the therapist. In a paper written in 1964 (5), I summarized the classical psychoanalytic position as holding that the analyst must require sacrificial fees from his patient because they provide the patient with motivation, generate analytical material, and are beneficial to the countertransference. However, reports of actual experiences with free and low-cost analysis available at that time suggested that such a payment milieu was not fatally inimical to treatment; rather, despite theoretical preconceptions and individual examples to the contrary, the evidence indicated that psychoanalysis can proceed successfully in the absence of fees or with low fees. This finding supported the view that motivation for patients to work at psychoanalysis (or in psychotherapy generally) is not simply a function of the willingness to spend money for treatment; such a willingness is an evidence of motivation but it cannot provide motivation. There is ample experience that motivation to work in psychoanalysis may very well be present in high degree even when the treatment does not represent a financial sacrifice. It appears that the fee is a more important source of motivation for the therapist than for the patient.

Since 1964 third-party payment has become far more common than formerly, and a considerable amount of experience has accumulated on the effects of third-party insurance payment on psychoanalytic and other forms of psychotherapy. A recent report by Halpert (6) sounds a warning note, on the basis of two cases, that insurance payment may offer a focus for resistance, making the analytic task more difficult.

There is also a school of thought which holds that no form of psychotherapeutic treatment in which payment is not a private matter between therapist and analysand can be considered psychoanalysis. This represents an example of classification by definition and if it is accepted, one will have to find a new name for what many fully qualified psychoanalysts with impeccable credentials are doing with patients from whom they receive third-party payment under the mistaken notion that they are practicing psychoanalysis.

My own experience and that of the colleagues with whom I have discussed this matter seems to support the view that when payment is made partially through a third party, some problems appear in the psychoanalysis or other intensive psychotherapy that otherwise would not be present. Some are like the ones cited in Halpert's cases, where the narcissistic gratification the patients were reported to have received in the form of fulfillment of fantasies of omnipotence from the fact that they themselves did not have to pay for the treatment was sufficient to interfere with their motivation to work in their analyses.

However, fantasies of this kind often appear in analysis and are subject to interpretation and working through like any other kind of fantasy. It sometimes may even be an advantage to the analysis to have the patient feeling that he is getting something for nothing mobilized by the fact that he does not have to pay, in exactly the same way that other fantasies may be mobilized and must be interpreted when the patient must make regular payments. At any rate, the practice of psychoanalysis and other intensive psychotherapy with third-party payment is flourishing where such payment is available, and there is no reason to believe that the results of such psychotherapy are in any way inferior to those produced in direct-payment settings.

The Trend Toward Greater Accountability

In making the above statement, I am aware that I am venturing on rather shaky ground because of the uncertainty that pertains to the whole field of outcome studies in psychotherapy. The reasons for this state of affairs are complicated. The most important may simply be the extreme difficulty of the task, but it also seems likely that practitioners of psychotherapy have not been particularly motivated to scrutinize their work and that of their colleagues in a manner approaching scientific standards. However, this is a situation that inevitably will change under the economic spur of third-party intervention as the various carriers increasingly supplement the monetary carrot with the stick of accountability. Insurance officials and their actuaries are going to want to know what they are paying for, whether patients are being treated under proper indications, and whether psychotherapeutic practices are being abused. They expect this kind of accountability from surgeons, and although somewhat confused by the differences between psychiatry and the other medical specialties, they are not likely to regard psychiatrists as any more sacrosanct or immune from questioning than other medical specialists.

Also, we are undoubtedly entering an era when organizations of psychiatrists and other psychotherapists are going to have to negotiate contracts with various insurance carriers, and in these negotiations the representatives of psychiatry will have to answer such questions if they wish their services to be included under insurance coverage. Thus we see that an already troublesome problem—the criteria for various forms of psychotherapy and evaluation of their effectiveness—has been given a new urgency by the increase in third-party payment.

A relatively new development in psychiatry is the peer review committee, which makes recommendations about such matters as fees and indications for type and duration of treatment when these are called into question in individual cases. It is difficult to imagine that monitoring agencies of this kind would ever have been considered necessary or useful before the interposition of a third-party payment mechanism between patient and

therapist. There is little doubt that the near future will see an increasing use of such quality control methods; the real question is whether they will be adequate and acceptable or whether such functions will be taken out of the sole control of psychotherapists. Whether this latter eventuality, with its far-reaching effects, ever comes to pass is dependent on the attitude of psychiatrists who specialize in psychotherapy not only toward peer review committees but also toward all the other issues involving third-party payment that I have raised.

If they take the position that everything which happens between their patients and themselves is nobody's business but their own, they will be in a difficult and anxiety-provoking situation in dealing with third-party requirements; they may be better off refusing to accept patients who pay their bills

by such means. If, however, they accept the queen's shilling of insurance payment for part of their patients' financial obligations to them, they will have to come to terms with some of the hard questions I have touched upon.

REFERENCES

1. Married man asks to be billed for psychiatric care of mistress. JAMA 218:1443, 1971
2. Psychologists bid for inclusion in health insurance legislation. Psychiatric News, Dec 1, 1971, p 1
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, DC, APA, 1968
4. Bevan W: The topsy-turvy world of health care delivery. Science 173:985, Sept 10, 1971
5. Chodoff P: Psychoanalysis and fees. Compr Psychiat 5:137-145, 1964
6. Halpert E: The effect of insurance on psychoanalytic treatment. J Amer Psychoanal Ass 20:122-133, 1972

Changing the *Journal's* Volume Year

Since some confusion has resulted from the *Journal's* current practice of beginning a new volume year in July, it was suggested that a change be made so that the *Journal's* volume year coincides with the calendar year. The Editorial Board has decided, and the APA Board of Trustees has approved, that the change be made in January 1973. Volume 129 will be the short volume (July-December 1972), and Volume 130 will begin with January 1973.

Women Who Seek Therapeutic Abortion: A Comparison with Women Who Complete Their Pregnancies

BY CHARLES V. FORD, M.D., PIETRO CASTELNUOVO-TEDESCO, M.D.,
AND KAHLILA D. LONG

The authors compared 40 women seeking therapeutic abortion with 52 pregnant women who were not requesting abortion. The women in the abortion group complained more frequently of depression, anxiety, insomnia, loss of libido, anorexia, and suicidal ideation. Their average MMPI scores were significantly elevated for most scales. The women in the abortion group were more likely to have received psychiatric treatment, to have poorer sexual adjustment, and to reject the maternal role. The concept of "accidental" pregnancy is questioned, since women in both groups made little effort to prevent conception.

ALTHOUGH SO FAR most reports about abortion have dealt either with the moral issues surrounding this procedure or with its psychological effects, some recent surveys have studied the women who request abortion and have suggested that they may have some common psychological characteristics. Simon and his colleagues (1, 2) concluded that these women show disturbances of feminine identity, tend to reject their maternal role, and use pregnancy as a way of acting out sadomasochistic impulses. Kimball (3) has noted that teen-age pregnancies may be part of an attempt to establish sexual identity and that unwanted pregnancies in older women may aim at denying the approaching menopause. Rapoport (4), in a study of a group of

American women who requested abortion in Sweden, found that in many cases conception appeared to be the result of conflictual and disorganized sexual behavior. Kenyon (5) also reported a high frequency (62 percent) of sexual problems in his series of women who sought abortion. The possibility that unwanted pregnancies may not be "accidental" is suggested by reports that conception often cannot be traced either to ignorance of sexual function or birth control techniques or to contraceptive failure (1, 3, 6).

Unfortunately, most studies in this area have suffered from sampling deficiencies. Reports from a particular hospital may be biased by religious or socioeconomic criteria or by the policies of that hospital's abortion committee. Lack of adequate controls has made it difficult to interpret data obtained from widely differing population samples. When an effort has been made to include a control group, the results often have been less satisfactory. Kenyon (5), for example, employed a comparison group of women who were routine psychiatric referrals. These nonpregnant, obviously neurotic women cannot be considered a suitable control group.

With these considerations in mind, we decided to compare a group of abortion applicants with a control group of pregnant women selected at random from the hospital's prenatal clinic. We particularly wish to emphasize that the abortion group consisted of consecutive *applicants* for abortion rather than those who were finally *selected*. We have already reported our experience with those women who actually had abortions (7).

Method

Forty consecutive women requesting abor-

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TABLE 1
Comparison of Religious, Racial, and Economic Characteristics

ITEM	ABORTION GROUP (N = 40)		CONTROL GROUP (N = 52)		SIGNIFICANCE
	NUMBER	PERCENT	NUMBER	PERCENT	
Roman Catholics					
Active and inactive	16	40.0	15	28.8	n.s.
Active only	1	2.5	8	15.4	p < .05
Protestants, active	8	20.0	12	23.1	n.s.
Public aid recipients	14	35.0	17	32.7	n.s.
Racial minority group members	16	40.0	27	51.9	n.s.

tion at a large county hospital were referred for psychiatric evaluation. This evaluation consisted of three interviews, one by a psychiatric social worker and the others by two psychiatrists. The interviews were rather structured and questions were asked to clarify such items as family background, personal history, and use of contraceptive methods. Also, all subjects (except two who were illiterate) completed the Minnesota Multiphasic Personality Inventory (MMPI).

The control group was selected at random from among patients in the obstetrical clinic according to their marital status, as indicated by their charts. Although equal groups of single, divorced or separated, and married women were chosen, the interview occasionally indicated that the marital status specified on the chart was in error; therefore, reassignment changed the ratios slightly. The majority were in the third trimester of pregnancy, although a few were in the second trimester or late in the first trimester. Each woman was told that her cooperation was requested so that we could learn more about current views on pregnancy and abortion. All those who were approached proved cooperative. Each woman was seen for one interview either by a psychiatric social worker or by a psychiatrist. The interviews were largely structured, although the women were encouraged to give their opinions and personal histories in a spontaneous manner. In addition, all (except one who was illiterate) completed the MMPI.

Findings

Comparison of two groups of pregnant women, those seeking therapeutic abortion and those planning an uninterrupted pregnancy, revealed many similarities and some significant differences.

The two groups were of the same socioec-

onomic status, as judged by the percentage of women receiving welfare and by their average educational level. All were medically indigent. In addition, both groups showed a very similar racial and religious composition; the ratio of Protestants to Roman Catholics was approximately the same, although there was a significantly lower percentage of practicing Roman Catholics in the abortion group (see table 1). When compared according to marital status, no significant differences were found in age or educational level (see table 2). Similarly, the women's average number of siblings showed no significant difference (4.4 for the abortion group and 4.0 for the control group). A broken home due to parental death or divorce prior to age 16 actually had occurred more often in the control group (31 of 52, 59.5 percent) than in the abortion group (16 of 40, 40.0 percent), but this finding did not reach statistical significance. The groups were very similar in prevalence of antisocial

TABLE 2
Average Age, Education, and Parity by Marital Status

ITEM	ABORTION GROUP	CONTROL GROUP	SIGNIFICANCE
Age			
Single	19.5 years	21.6 years	n.s.
Married	27.7	24.2	n.s.
Divorced or separated	27.8	25.4	n.s.
Education			
Single	11.4 years	12.3 years	n.s.
Married	11.2	11.6	n.s.
Divorced or separated	11.5	11.5	n.s.
Parity			
Single	0.4	0.6	n.s.
Married	3.3	1.6	p < .05
Divorced or separated	2.7	1.6	n.s.
Number of children living with the woman			
Single	0.3	0.3	n.s.
Married	2.9	1.4	p < .05
Divorced or separated	2.4	1.4	n.s.

TABLE 3
Comparison of Personal Histories

ITEM	ABORTION GROUP		CONTROL GROUP		SIGNIFICANCE
	NUMBER	PERCENT	NUMBER	PERCENT	
Came from a broken home	16	40.0	31	59.6	n.s.
Antisocial behavior	11	27.5	13	25.0	n.s.
Received psychiatric treatment	17	42.5	11	21.1	$p < .05$
Masochistic behavior	14	35.0	3	5.8	$p < .001$

behavior (including drug use, school disciplinary problems, or arrests): 11 of 40 (27.5 percent) in the abortion group gave a positive history, compared with 13 of 52 (25.0 percent) in the control group (see table 3).

However, the groups differed significantly in terms of the women's average number of children. When compared by marital subgroup, the single women had the same average number of children (0.3) but the married and the divorced or separated women in the abortion subgroups had more children than the control group. This difference was significant ($p < .05$) for the married women (see table 2).

A history of psychiatric illness was more common in the group requesting abortion. Seventeen of the 40 (42.5 percent) had been hospitalized or had sought outpatient treatment, as opposed to 11 of 52 (21.1 percent) in the control group ($p < .05$). Both groups included women with histories of schizophrenia, suicidal gestures, and brief outpatient psychotherapy. In the abortion group there were four schizophrenics who had had extended hospitalization, in contrast to one in the control group. Among the other control group women, consultation for outpatient treatment or brief hospitalization had been primarily because of crisis situations due to marital or family problems. No patient had received, or was involved in, intensive psychotherapy.

Masochistic behavioral patterns were frequently reported by women in the abortion group. Many women had been involved in relationships with men whom they described as abusive and assaultive. Other women had engaged in self-destructive behavior, such as cutting themselves with knives or scissors. For the purpose of statistical comparison, masochistic behavior was strictly defined as self-inflicted injury or as a prolonged relationship with a man described as physically assaultive (see table 3). Using these criteria, women in the abortion group were signifi-

cantly more masochistic than those in the control group ($p < .001$). However, the former also were more self-defeating in a variety of ways more difficult to define precisely. For example, four women reported that they were supporting irresponsible husbands and several others reported that their husbands were alcoholics and/or philanderers.

The use of contraceptive methods is an important indicator of the woman's motivation toward prevention of pregnancy. The majority of the women in both the abortion and control groups had adequate knowledge of, and resources for, contraception; actual failures of the method were infrequent and generally limited to cases where vaginal foams alone had been used (see table 4). In apparent contradiction to the frequently expressed feeling that "I could not tolerate a baby," many women in the abortion group had used no contraceptive method whatever or had used available methods haphazardly. Coitus interruptus was reported by five of the abortion group but by none of the control group. Consciously planned pregnancies were in a minority in the control group (nine of 52) as well as in the abortion group (two of 40). The main difference was that the pregnancy, although not planned, was much more likely to be ego syntonic for the women in the con-

TABLE 4
Comparison of Data on Contraception*

ITEM	ABORTION GROUP		CONTROL GROUP	
	NUMBER	PERCENT	NUMBER	PERCENT
Availability and knowledge of contraceptive methods				
Adequate	33	82.5	46	88.5
Limited or inadequate	7	17.5	6	11.5
Planned pregnancies	2	5.0	9	17.3
Contraceptive failures**	4	10.5	7	16.3

*None of the comparisons produced a significant difference between groups.

**Based on a percentage of the "unplanned" pregnancies, not a percentage of the entire group studied.

TABLE 5
Symptoms Reported During Pregnancy

ITEM	ABORTION GROUP		CONTROL GROUP		SIGNIFICANCE
	NUMBER	PERCENT	NUMBER	PERCENT	
Depression	39	97.5	29	55.8	$p < .001$
Anxiety	33	82.5	30	57.7	$p < .05$
Insomnia	31	77.5	26	50.0	$p < .01$
Loss of libido	29	72.5	26	50.0	$p < .05$
Crying spells	25	62.5	25	48.1	n.s.
Suicidal ideation	22	55.0	4	7.7	$p < .001$
Headaches	20	50.0	24	46.1	n.s.
Anorexia	18	45.0	13	25.0	$p < .05$
"Morning sickness"	11	27.5	27	51.9	$p < .05$

trol group. For several women in the married group, the pregnancy had precipitated the wedding and such comments as "I knew he would marry me if I got pregnant" were heard.

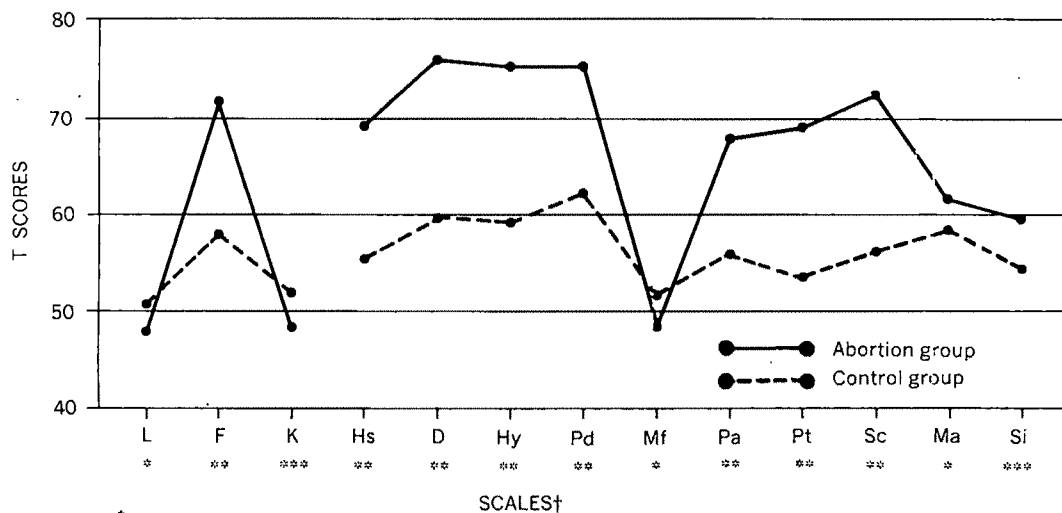
When questioned about sexual attitudes only 45 percent of the abortion group professed enjoyment of intercourse, as opposed to 65.5 percent of the control group ($p < .05$).

The most striking difference in this comparison study was in regard to maternal attitudes. Only eight of 40 (20 percent) in the abortion group made overtly positive comments about their self-image as mothers as opposed to 43 of 52 (85.5 percent) in the control group ($p < .001$). Moreover, 21 of 40 (52.5 percent) in the abortion group made

overtly negative comments about the pregnancy, such as "I'd rather have cancer than another baby," whereas such comments were rare (three of 52, 5.7 percent) in the control group ($p < .001$). The effects of such maternal attitudes were reflected in the appearance of the children brought to the interview by the women in the abortion group; typically they were dirty, unhappy, and ill-behaved.

The women who requested abortion conveyed a sense of agitation and despair, a feeling that their situation was intolerable and must not be allowed to continue. Many complained of suicidal ideation (55.0 percent) and almost all stated that they were depressed and anxious. Frequently reported symptoms were insomnia, anorexia, loss of libido, crying spells, and headaches. Interest-

FIGURE 1
Comparison of Average MMPI T Scores



*n.s.
** $p < .001$.
*** $p < .05$.

†Abbreviations: see table 6.

TABLE 6
Average MMPI T Scores by Marital Status

SCALE*	ABORTION GROUP			CONTROL GROUP		
	SINGLE (N = 10)	MARRIED (N = 12)	DIVORCED OR SEPARATED (N = 16)	SINGLE (N = 16)	MARRIED (N = 20)	DIVORCED OR SEPARATED (N = 15)
L	52.0	47.0	46.2	51.8	53.2	52.9
F	73.1	71.6	75.5	57.5	57.3	58.6
K	52.8	46.7	46.4	53.8	50.3	51.7
Hs	66.8	74.6	66.7	54.8	51.2	54.3
D	73.7	78.2	75.3	57.9	60.7	59.4
Hy	75.6	78.2	72.9	63.0	58.0	57.2
Pd	82.2	73.5	75.8	70.6	58.3	58.0
Mf	49.9	54.0	43.7	50.5	53.7	50.7
Pa	72.0	68.8	64.9	59.2	53.7	55.3
Pt	73.2	68.8	68.0	55.6	52.7	53.3
Sc	78.8	68.5	71.8	60.9	56.3	54.8
Ma	66.9	61.8	58.2	59.5	57.2	57.5
Si	55.8	60.3	61.3	50.5	55.0	57.3

*Abbreviations: L = lie, F = frequency, K = correction, Hs = hypochondriasis, D = depression, Hy = hysteria, Pd = psychopathic deviate, Mf = masculinity-femininity, Pa = paranoia, Pt = psychasthenia, Sc = schizophrenia, Ma = hypomania, Si = social introversion-extroversion.

ingly the complaint of "morning sickness" was significantly lower in the abortion group (27.5 percent) than in the control group (52.0 percent). The frequency of reported symptoms for both the abortion and control groups is listed in table 5.

Married and unmarried women gave very similar explanations of why they were seeking abortion. Shame and guilt over pregnancy out of wedlock were primary concerns of only two of the 26 unmarried women. Rather, the recurrent theme was that the baby would interfere with narcissistic needs and reality-oriented concerns.

Even though pregnancy seemed to us to be socially or economically undesirable for the majority of the medically indigent control group, only 11 of 52 women had consciously considered abortion. Such comments as "Children are God-given" and "A woman should have children" represented typical attitudes. Of the 11 women who had consciously considered abortion, three thought they would probably seek an abortion if they could still reconsider their decision. Two others, in the third trimester, still had ambivalent feelings about their pregnancy and the other six felt comfortable with their decision to continue the pregnancy.

The abortion and control groups were also compared according to their performance on the MMPI. Average T scores were computed for each group as a whole (see figure 1) and also by subgroup according to marital status (see table 6). The two groups proved sharply different; the therapeutic abortion group scored significantly higher on all but three of

the scales. The highly deviant scores of the therapeutic abortion group reflected both the chronic emotional difficulties of these women and their acute distress over the unwanted pregnancies.

Because a prior report (1) had suggested that T scores for scale Pd (Psychopathic deviate) often exceed T scores for scale Mf (Masculinity-femininity) by 20 or more in women requesting abortion, we compared our abortion group with the control group in this regard. Of the 38 MMPI profiles of abortion applicants, 26 (68.5 percent) had scale Pd T scores that were greater by 20 or more than those of scale Mf. By contrast, of the 51 profiles of the control group, only 12 (23.5 percent) had T scores for scale Pd that exceeded those of scale Mf by 20 or more. This difference is significant at the .001 level.

Discussion

Our findings indicate that women who requested abortion at our hospital differed distinctly from those chosen at random from the obstetrical clinic. Characteristics previously described (1, 2) including rejection of the maternal role and a masochistic life-style were, on the whole, confirmed by our comparison study. Also confirmed was the observation that most abortion applicants have failed to use any contraceptive methods. This is a particularly interesting issue since it suggests that the pregnancy is not nearly as "accidental" as the woman usually considers it to be. It is our opinion that conception is often related to unconscious efforts to resolve con-

licts over feminine identity and that abortion, is requested especially when the occurrence of pregnancy fails to resolve these conflicts. Even for the control group planned pregnancies were in a minority, yet these women's sense of comfort about being pregnant suggests that for them the pregnancy successfully met their individual needs.

Contrary to the popular belief that shame over pregnancy out of wedlock is the major motivation for abortion, we observed that, at least in this socioeconomic group, embarrassment is a minor and infrequent concern. Much more important was the woman's rejection of motherhood with all of its attendant demands. Our impression is that these women tend to be narcissistic and regard the fetus as a competitor for the succorance and dependent care they themselves obviously require.

Several points deserve special mention. The increased use of coitus interruptus by women seeking abortion has also been reported by Kenyon (5), leading us to believe that this is not a spurious finding. We consider this further evidence of their conflicts and ambivalence about sexuality rather than simply of inadequate contraception. Also of particular interest is the finding that the abortion group had less "morning sickness" than the control group. Kenyon (5) made a similar observation. However, he questioned the role of emotional factors in this symptom on the logic that vomiting should prove most severe in women who want an abortion so desperately. We would interpret matters differently. We suspect that vomiting tends to be most severe in those who need to deny their negative feelings and who therefore must convey symbolically, by means of a conversion symptom, their rejection of the pregnant state ("throwing it up"). By contrast, the women who request abortion and who thus proclaim openly their dislike and rejection of the pregnancy have no need for this symptom.

Comparison of the religious composition of both samples revealed few differences; except for the finding that practicing Roman Catholics were significantly underrepresented among those seeking abortion, religion did not seem as important in formulating attitudes as one might have thought.

Some comments about the experimental design and possible complications in analyzing

the data appear in order.

The patients in the control group were selected at random according to marital status so that the sample would be representative of the hospital population and accurately reflect its demographic characteristics. On the other hand, a control group matched for age, number of children, length of marriage, etc., might have brought into sharper focus the psychological differences between the two groups. For example, women in the control group tended to be younger and have fewer children than those in the abortion group, raising the question whether, at least in some cases, the latter sought abortion because they considered themselves older and with families already complete. We do not believe that this was a primary factor; rather, we are inclined to view the request for therapeutic abortion as the outcome primarily of conflicts over sexuality and mothering. At least in this group of women, who are so outspokenly rejecting of the maternal role, the presence of large families seemed to reflect mainly the repetitive acting out of these conflicts.

Some attention must be given to the validity of the histories and MMPI data obtained from these two groups. The women in the abortion group may have believed that they were more likely to be approved for abortion if they emphasized or even exaggerated their distress. By contrast, the control group may have been somewhat reticent to discuss their personal problems with someone who they felt could offer them little. We can make no definite statements about the validity of the information obtained; however, we believe that we established good relationships with these patients and feel comfortable with their histories as offered. Pratt and others (8), in a follow-up evaluation of women who requested abortion, found that five of 26 had offered a falsely positive history of suicidal ideation but, surprisingly, three had actually experienced suicidal ideation and had denied it.

Another factor to be considered is that the applicants for abortion were in the first or early second trimester of their pregnancies while most of the control group women were in the second and third trimester. It is possible that some of the women in the control group had been more ambivalent about their pregnancies at an earlier stage but had rationalized or repressed such feelings by the

time they were interviewed; however, we could find no clear evidence that a significant shift in their attitudes about the pregnancy had occurred.

The MMPI data showed marked differences between the groups although the F scale was elevated for the abortion group and this could be interpreted as denoting an exaggeration of symptoms. However, in the abortion group this scale was not elevated disproportionately to other scales. Also, for those women who had abortions and who repeated the MMPI six months later, the F scale remained relatively elevated despite the fact that there was no apparent motivation to exaggerate symptoms at that time (7). On the whole, the MMPI data for the abortion group were strikingly similar to those obtained in a prior prospective study by Brody and others (9). Our finding of frequent Pd scale T scores greater by 20 or more than those of the Mf scale confirms the report of Simon and others (1). They have interpreted this as suggestive of a masochistic character pattern in women who exaggerate feminine characteristics in response to poor feminine identity. We would agree that many of these women

have difficulties with aspects of their feminine identity as well as distinct masochistic traits.

REFERENCES

1. Simon NM, Senturia AG, Rothman D: Psychiatric illness following therapeutic abortion. *Amer J Psychiat* 124:59-65, 1967
2. Simon NM, Rothman D, Goff JT, et al: Psychological factors related to spontaneous and therapeutic abortion. *Amer J Obstet Gynec* 104:799-806, 1969
3. Kimball CP: Some observations regarding unwanted pregnancies and therapeutic abortions. *Obstet Gynec* 35:293-296, 1970
4. Rapoport JL: American abortion applicants in Sweden. *Arch Gen Psychiat* 13:24-33, 1965
5. Kenyon FE: Termination of pregnancy on psychiatric grounds: a comparative study of 61 cases. *Brit J Med Psychol* 42:243-253, 1969
6. Ford CV, Atkinson RM, Bragonier JR: Therapeutic abortion: who needs a psychiatrist? *Obstet Gynec* 38:206-213, 1971
7. Ford CV, Castelnuovo-Tedesco P, Long KD: Abortion: is it a therapeutic procedure in psychiatry? *JAMA* 218:1173-1178, 1971
8. Pratt SL, Rappaport RG, Barglow P: Follow-up of therapeutic abortion. *Arch Gen Psychiat* 20:408-414, 1969
9. Brody H, Meikle S, Gerriste R: Therapeutic abortion: a prospective study, I. *Amer J Obstet Gynec* 109:347-353, 1971

New Subscription Rates for the *Journal*

To keep pace with rising costs, the Association has found it necessary to increase the subscription fees for *The American Journal of Psychiatry*. Effective January 1, 1973, the new rates for the *Journal* will be: U.S., \$15; Canada and South America, \$15.75; foreign, \$18; single copy, \$1.75 plus postage.

The Jewishness of Jewish Young People: A Symposium

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THE COMMISSION on Synagogue Relations, an organ of New York City's Federation of Jewish Philanthropies, maintains a Committee on Judaism and Mental Health. Recently this committee addressed itself to the fact that social and family implications of being Jewish are generally ignored in the psychiatric treatment of Jewish patients. This neglect was more understandable in a period when social and individual differences were played down than it is in the present era of concern with ethnicity and community. Thus it was thought that the reasons for the minimizing of Jewishness as a source of pathogenic conflict by both Jewish and non-Jewish psychiatrists deserved some study. In an initial effort to encourage their colleagues to review their attitudes on the issue, four members of the committee volunteered to prepare brief presentations for the purpose of exchanging views.

Each of the four is active in private practice and institutional psychiatry and participates as a psychiatrist in Jewish communal affairs.

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Their papers are abstracted below.

Mortimer Ostow, M.D.

Because many psychiatrists fail to understand the experience of being Jewish, they are handicapped in their clinical assessment of certain symptoms and acting-out activities of their Jewish patients. The problem is more urgent in the case of young Jews. Few non-Jewish psychiatrists, despite their friendly curiosity, comprehend the nature of the communal pulls, their pervasiveness and depth, and the strength of the historical forces to which young Jews are willy-nilly subject. Therefore it is difficult for them to see behavior relating to Jewishness as anything other than parent-oriented obedience on the one hand or protest on the other.

Among Jewish psychiatrists one finds a large number who have adopted an indifferent position vis-à-vis the Jewish community and who have opted to view themselves as citizens of the world. The positive expression of Jewishness by their patients threatens this view and encourages them to see manifestations of Jewishness as symptomatic or unwholesome.

To consider being Jewish a matter of religion, in the sense that an American may be Jewish or Catholic or Protestant, is to miss the point. The nonreligious Jew is as much a Jew as the observant Jew, and his Jewishness is likely to exert a strong influence on his be-

havior. The nonpracticing Protestant, on the other hand, may be minimally influenced by that status. To consider being Jewish a matter of being a member of a social minority is equally misleading. The relevant qualities of being Jewish exist in Israel where the Jews are a majority; similar qualities do not exist in other minorities in this country.

Though he did not write about it, Freud indicated in at least two places the pervasive influence of being Jewish. In a proposed Hebrew translation of "Totem and Taboo" in 1930, he wrote of an "essence of being Jewish," which would some day "become accessible to the scientific mind" (1). In 1926, in an address to the Society of B'nai Brith, he wrote that his attraction to Jewry was irresistible and was motivated by "many obscure emotional forces, which were the more powerful the less they could be expressed in words, as well as a clear consciousness of inner identity, the safe privacy of a common mental construction" (2).

Special Features of Jewish Living

There are three features of Jewish living that play a significant role in every Jew's view of his relation to the world around him. The first is the fact that for the past 2,000 years (until the rebirth of the Jewish state), Jews have lived in countries other than their own, as guests who were welcomed, tolerated, or abused, depending upon the temporary mood of their hosts. Second, the rebirth of the State of Israel imparts a measure of pride and self-respect in every Jew, no matter where he lives, and seems to represent a magical fulfillment of the longing of every Jew who has lived during the past two millennia and who has been exposed to even minimal religious tradition. It creates a powerful impression of an uncanny return to the infancy of the group. Third, the perennial recurrence of persecution threatens every Jew, no matter where or when he lives, at one level of consciousness or another.

Partly as a result of these three shaping influences, and partly as a result of its history, literature, and the characteristics of its constituency, the Jewish community over the generations has possessed certain properties that affect each of its members. Perhaps the central quality of the subjective experience of being a Jew is the feeling that one is a mem-

ber of an extended family. Second, within the Jewish community there is no hierarchy of power. This dependence upon the strength of fraternal feelings rather than on formal, legally constituted authority possesses disadvantages from political and military points of view but contributes qualities of resilience and creativity. Third, Jewish communities, whether in their own land or as guests in the lands of others, have characteristically remained more or less isolated from the surrounding communities. Fourth, lacking a formal structure, the Jewish community subscribes to the principle of elitism. Not only does it regard itself as elect and therefore obligated to adhere to an unusually high set of ethical and moral standards, but it recognizes an elite within itself, selected by such criteria as intellectual accomplishment, philanthropy, and community service. Finally, the phenomenon of recurrent persecution and its constant working over as a trauma creates the impression that the Jews are obsessed with suffering. Whereas at times it seems as though the Jewish community incurs more difficulties than absolutely necessary, a review of Jewish history and literature lends no support to the notion that masochism plays a consistent or important role among Jewish communities.

Despite the fact that a formal Jewish community does not exist in the United States today in the sense that organized communities existed through medieval and even into modern times in Europe, there is nevertheless an invisible Jewish community in the United States today that incorporates almost every Jew. Many Jews express their membership by formal affiliation with organizations of specifically Jewish interest: religious, social, Zionist, eleemosynary, or self-defense. Many send their children for religious education; others confine their expressions of obligation to the Jewish community by making charitable gifts to community organizations operating under Jewish sponsorship, such as hospitals or community centers. Perhaps the most dramatic demonstration of this invisible Jewish community was the almost universal intense and generous support of Israel by American Jews, organized and unorganized, affiliated and unaffiliated, at the time of the Six-Day War. While the integrity of the Jewish community is strengthened by external pressure, it does

exhibit an inner cohesion as well.

The process by which Jews transmit their values and their commitment to group cohesion from generation to generation is poorly understood. However, the fact of this transmission cannot be denied.

In the United States today, liberalism seems to be characteristic of the political attitudes of the Jewish community. Jews have not always been liberals and some historians see current American Jewish liberalism as a carry-over from the defensive attitudes of their parents and grandparents toward oppressive regimes in Eastern Europe. One of the important current problems facing the American Jewish community is that while many Jews serve liberal causes with enthusiasm, liberalism in some quarters is apparently becoming tainted with anti-Semitism, masquerading as anti-Zionism, anti-imperialism, and discrimination in favor of other minorities.

Reverence for learning has always been cherished as a value within Jewish communities. The penchant of Jews for professional education is generally recognized to be a derivative of this idealization of education. However, one unfortunate consequence of the promotion of this value is the encouragement of large groups of Jewish young people to register in institutions of higher education even if they are poorly motivated; their poor personal motivation subsequently results in their becoming involved in campus protest movements. Often what they are protesting against seems to be, in large part, the pressure to go to school.

Some of the forms of behavior adopted by Jewish young people in their efforts to find a satisfactory resolution of their conflicting impulses involve actions affecting the Jewish community and their membership in it. The more extreme forms of behavior are likely to be symptomatic of illness and to be directed primarily at affecting their parents. The less extreme forms are more likely to be expressions of their efforts to find a point of minimal stress and maximal gratification within society; this is not necessarily or seriously pathological. Their existence within two communities simultaneously—the Jewish and the general—offers them more options but also subjects them to more conflicting pulls than is the case with their non-Jewish contemporaries.

Intermarriage and Other Problems

Intermarriage has become one of the most common of the distressing forms of adolescent acting-out within the Jewish community. It is distressing because the parent feels it as a repudiation and an offense, and it is serious because it is not easily reversed, especially after the birth of children. The subject of intermarriage is a complex one. The name itself covers such different phenomena as marrying down, that is, marrying a partner of inferior social status; marrying up, that is, marrying a non-Jew of higher social or economic status; and marrying across, that is, marrying a partner who is not Jewish but is in every other way suitable. A moment's consideration will reveal that these different phenomena arise from different origins and different motivations and betray different degrees of pathology.

Some individuals engage in direct attacks upon the Jewish community. Others express their hostility by disparaging their fellow Jews. The propagation of malicious stereotypes of Jews by Jewish writers belongs in this category. The inclusion of vulgar Yiddishisms in modern journalism I consider a malicious presentation of Jewish "culture" at its worst.

Formal religious conversion out of the Jewish community into another religious community occurs relatively infrequently nowadays in the absence of gross psychopathology. At other times and places it implied opportunism rather than illness.

Similar in some ways to those whose liberalism encourages them to support movements with anti-Semitic implications are individuals who pride themselves on having risen above "narrow partisanship" to a kind of universalist concern for all of humanity. These Jews do not attack the Jewish community openly but merely try to ignore it—often disdainfully.

While many forms of conflict resolution among Jews involve distancing themselves from the Jewish community, other forms of resolution intensify their involvement. There may be a kind of conversion to an intensely religious life; there may be excessive pro-Jewish militancy; or the young person may "marry in"—that is, marry a partner whose origin and commitment pull him closer to the center of the Jewish community.

From these considerations, one would be

justified in inferring that the feeling of Jewish communality touches every Jew, across generations and across geographic boundaries. Some Jews accept it and comply with it, others rebel against it, and still others deny or ignore it. Yet no Jew can escape it. Proper psychiatric treatment of Jews and especially of Jewish young people requires that the psychiatrist take cognizance of the influence of this powerful social force and, where it is a problem, help his patient to come to terms with it.

Mortimer J. Blumenthal, M.D.

The child enters puberty with a set of familially determined cultural values and attitudes that are the outcome of his entire earlier life experience at home and in school. During adolescence, as the child progressively separates himself from his family and acquires autonomy, his identity is molded internally by maturational processes and externally by the living environment in which he works out his destiny (3). This environment includes his family of birth, his neighborhood, and subsequently the settings of later adolescence that are significantly more distant from home such as college, military service, and the vocational milieu.

The adolescent phase not only permits a basic restructuring of the psych. elements that enter into personality but also represents the final common pathway to adult identity (4).

More often than not, issues of Jewish identity seem to be peripheral to the presenting problems of the patient and are regarded as epiphenomena. Because therapeutic efforts are narrowed to the individual in his family, the clinician is not attuned to perceive the longer intergenerational sequences whereby ethnic identity structures may show striking cumulative alterations whose significance may be profound for both the patients and society.

In the vignettes that follow, the focus is on the vicissitudes of the Jewish identifications. Only enough data about other aspects of the cases are included to provide a minimal clinical picture, which will not be elaborated upon as it is outside the scope of this paper.

Case 1. Ms. A., an 18-year-old girl and the

daughter of a Hebrew school teacher, was referred because of the family's concern about her adopting an irreligious life-style. The patient was also eager to come for help because of self-doubts about her changing values.

The parents had lived apart for several years because of serious incompatibility. Sometime before entering treatment, the patient had had to leave the mother's home because of frequent quarreling between the two of them. She went to live with her father. While there she became active in radical politics and acquired a boyfriend. She subsequently left her father's home, became self-supporting, and lived alone, completely involved with her boyfriend and his radical circle.

The major thrust of this adolescent upheaval was motivated by two considerations: 1) severe criticism of and great disappointment in her parents, who did not, in their daily lives and dealings with each other, live up to their own religious standards of ethical and social conduct; and 2) severe anxiety associated with the revival of her early childhood conflicts, both oedipal and pregenital. Her solution of the conflict consisted of her successive separations from the homes of both her mother and her father, with the adoption of an increasingly secular and less Jewish life-style. Her boyfriend served as a surrogate family, fulfilling both paternal and maternal transference needs.

Case 2. Mr. B., a successful middle-aged businessman, sought treatment because of an extramarital attachment that troubled him although he had decided not to leave his wife.

Mr. B. and his wife had grown up in immigrant homes where Jewish identification and custom were strong. Their children had been given a moderately good religious education. Although Mrs. B. was fairly active in her synagogue, Mr. B. had always been indifferent except for a brief period after his son became a Bar Mitzvah, when he was a steady congregant. He became involved in the extramarital affair shortly after his son left for college.

He had many differences with his wife, particularly with regard to the rearing of their two children. The daughter was about to be graduated from high school and planned to go to a distant liberal arts college. The mother objected because the college had coed dormitories; she feared the possibility of marriage to someone of a different faith in such a setting. She preferred that the daughter attend a local university, where home ties would be maintained. On this issue the father took a more permissive stand and tended to support the girl's plan of separating herself from the family. The father said that it did not make any difference to him if his daughter married someone of a different faith.

Mr. B. illustrates clearly the role of a parent

whose unresolved (or revived) adolescent conflicts influence the stands he takes in guiding his children. This parent unconsciously identifies with the children's strivings for independence and sexual freedom. Wittingly or otherwise, he seeks to promote vicariously their separation from home as well as his own. Mr. B.'s sexual liaison and his decision to stay with his wife and preserve the family also dramatize other facets of his conflict. Here the father not only makes use of the distant college setting to encourage the child's separation from home but does so in such a way as to consciously risk the loss of her Jewish affiliations.

Case 3. Mr. C., an outstanding engineer, sought treatment because of a crisis in his life arising from his long-standing discontent with his marriage, in which he suffered impotence. In the course of treatment the vicissitudes of the Jewish identity of his family came to light, although they were not the focus of the therapy.

The patient's grandfather, an immigrant, had been very active in the Jewish community and an important lay leader in his neighborhood. One of his sons, the father of the patient, became disenchanted with Jewish communal life in his early teens and was never further involved with it.

In his childhood, the patient recognized his father's disdain toward and avoidance of Jewish pursuits. When he was 13, he was given one month of religious instruction to go through the motions of becoming a Bar Mitzvah, which, at the time, he felt to be a sham.

In his mid-teens, Mr. C. experienced a profound disillusionment with his parents. He regarded them as provincial, conservative, and unenlightened. In late adolescence he became enamored of a non-Jewish girl from whom he parted reluctantly at the insistence of his parents. Although he subsequently married a Jewish woman and had a family, the children were not exposed to Jewish influences because of the indifference of both parents.

It is notable that both the patient and his father experienced great disillusionment with their parents during adolescence. In four generations of this family a vital Jewish identity has declined to what would appear to be the bare remnants of a Jewish identification.

The American family is no longer rooted in its native locale. It has become more democratic, more mobile, more secular, smaller in size, and has tended to offer fewer social, recreational, and religious resources to its members (5).

The American Jewish family has similarly changed, despite its tradition of being close-knit (6). The parents as conveyers of Jewish values and standards often provide a less

meaningful education to their children in Jewish culture—not only in the formal sense of classroom instruction but in the example of their daily lives. The general attenuation of religion is reflected in a corresponding diminution of visible ritual and practice in the Jewish home. Acculturation to the majority mores reinforces the cultural erosion between Jewish generations (7).

It would appear that the vitality of adolescent Jewish identity in this country has manifested significant attenuation (8). This has occurred within a brief generational span. It has been fostered by the prevailing social and technological pressures of contemporary life, which are transmuting all social institutions, particularly the family. Without active commitment on the part of its adolescents, group culture cannot be transmitted or survive. In the consulting room one may observe some of the forces that are shaping the future of the American Jewish community.

Jacob A. Arlow, M.D.

In the past, as a rule, the transition toward adult identity was facilitated by a temporary attachment during adolescence to some leading personality who personified many of the ideal aspirations of the individual. Such a leader, drawn from life or history, exemplified in his own personality traits that were considered admirable and worthy of emulation. He constituted a concrete expression of an ego ideal. Around such idealized personalities followers organized themselves in groups. After a period of time, the individual usually separated himself from the group; in propitious instances, he retained vestiges of the original tie to the leader. These vestiges could be expressed in the form of continuing the ideals the leader represented or by transforming one's own personality in keeping with that of the idealized object (identification). In the current experience of adolescents, this type of group formation around an ego ideal image seems to play less of a role than does the influence of the peer group.

Early object ties place before the growing child models for identification. Identification may be facilitated by affection or they may grow out of fear, as in the case of identification with the aggressor (9). Child-rearing

practices and educational measures wittingly or unwittingly attempt to favor the molding of psychic structures in keeping with the traditional traits and values that the culture cherishes.

The conflicts of early childhood, especially those centering around the oedipal phase, are the most important dynamisms that can be enlisted pedagogically to influence the progression toward selecting and organizing appropriate values and ego ideals. The stories, fairy tales, and myths as well as the bits of history and the religious parables to which children of a particular culture are traditionally exposed constitute in reality versions of unconscious fantasies, shared in common (10, 11), which point the way to *preferred* modes of resolving the inexorable conflicts of childhood. By combining elements of vicarious gratification through identification with the central characters of the traditional tales, these mythic formations supply the "pleasure premium" that compensates the individual for his need to renounce his more basic antisocial wishes in favor of identifying with the heroes of tradition, the heroes (or heroines) who exemplify the ideal type of personality to emulate.

Ordinarily, these traditional myths are so much part of the cultural apparatus that it is impossible to appreciate how pervasive and influential is their effect on the developing child. When there is a conflict of cultures in the life of an individual or when one is exposed simultaneously to two different cultural traditions, the choice of ego ideals one makes and the timing and context of the identifications one effects enable us to understand the process more clearly. From such data one can trace the relationship between the conflicts of childhood and the choice of ego ideals and the consolidation of the sense of one's identity.

A fragment from the analysis of a child conducted by Ms. H. Adelsberg illustrates the process described above. The success of the therapist's efforts was in large measure related to her knowledge of the child's cultural traditions and to her sensitivity to how these traditions affected his psychological development. Without such sensitivity and appreciation, significant data in the case might have been missed entirely. The data have been organized around the concepts of ego-ideal formation, identity, and tradition.

Case 1. The patient, Morris, was the son of refugee parents, deeply religious Hassidic Jews. They came to the agency for help in their bitter marital discord. One of the issues that divided them was how to raise their children. Although both were practicing Jews, the father was intensely committed to a strict European type of religious upbringing for his children, one that would exclude secular American influences. The mother, on the other hand, was more liberal and not quite as opposed to the influences of the American scene. The marital difficulties and the various conflicts between the parents fit nicely into the oedipal struggle of the little boy.

When he was five, Morris was enrolled in a Hassidic school his father had chosen against the strenuous objections of Morris' mother. Morris resisted going to school and in class was hyperactive and disobedient, the ringleader in all the mischief. In addition, he had a number of neurotic symptoms: a tic in one eye, difficulty falling asleep, nightmares, and enuresis. He was afraid of dying and expressed concern over the intactness of his penis. He also had a great fear that if he did anything with his thumbs, blood would flow from them. In his fantasy and in his play activity he was clearly fascinated by weapons, particularly knives and guns.

Treatment covered two periods of time in Morris' life: between the ages of four-and-a-half and six, and between the ages of eight and 12. The therapist was able to study the development of his conflict and to explore the fantasies he used to express his conflicts. Through treatment, he was able to overcome his aggressiveness by means of changing his ego ideals. This was effected by his identifying with various mythological figures drawn from the two cultures in which he was raised—the Jewish Hassidic culture and the American culture, the latter deeply influenced by television, radio, and the movies. These identifications pointed the way to the resolution of his conflicts in the direction of sublimation and character transformation.

In the opening phase of treatment, the patient spoke of his fear of monsters who might attack him during the night. He dreamed of horrible animals emerging from the water and produced his first fantasy, one in which he imagined himself as Dracula, killing men and sucking blood from the necks of beautiful women. The sexual significance of this latter representation of Dracula's activities was not lost on this little boy. In the next phase of treatment, he was no longer identified with Dracula but remained intensely interested in stories about Dracula and in watching Dracula on television. After his fear subsided somewhat in the therapeutic situation, his fantasies began to change. Dracula now became the enemy from whom he was rescuing the beautiful woman and, in

his dreams, he saw himself as opposing the monster who came out of the sea.

Morris soon began to describe his war against the school. He would draw a cartoon picture of the rabbis, depicting them as devils peeping over the top of the Ten Commandments. It was in this context that his enuresis could be understood. He had learned in school that when you go to sleep the soul leaves the body and that it returns in the morning. Accordingly, he concluded that he was not responsible for his enuresis because his soul had left his body when he was wetting at night. He had also learned that there are two natures at war in each individual—a good nature (*Yetzer Tov*) and an evil nature (*Yetzer Rah*). In typical mythopoetic way he projected the conflict into the external world; he would daydream during his waking hours and at night would dream that the two forces, the *Yetzer Tov* and the *Yetzer Rah*, were at war with each other, using various techniques to conquer and prevail. Thus when the good intention is going along a certain path, the evil intention blocks the way and, to get around it, the *Yetzer Tov*, by a bit of 20th-century ingenuity, takes a plane and tries to fly over the *Yetzer Rah*.

On other occasions the good intention uses a gun—a water pistol—and shoots down the plane from the enemy camp, *Yetzer Rah*. It would be at this moment in his dream that Morris would wet the bed.

The same trend was continued on a more sophisticated level for the next few years. The warfare was separated from the religious tradition and was transposed into more recent events of world history. Morris saw "The Bridge Over the River Kwai" and took the general, played by Alec Guinness, as his model. This warrior was a decent man, devoted to his soldiers and honoring his responsibilities. From Morris' studies in religious school, however, he began to question the idea of having a soldier as his hero. He had been taught that the model to emulate was Aaron, the brother of Moses, who, in religious teachings, represents the leader of those who love and pursue peace. Thus by the process of reaction formation, Aaron became the new ego ideal. The patient began to give up his aggressiveness, lost his interest in knives, began to make peace with the teachers, and discovered to his satisfaction that he could be a very good student.

When he learned about Abraham Lincoln, he assumed that because his name was Abraham, he must have been Jewish. Since his own Hebrew name was Moses, he thought of himself as coupled with Abraham Lincoln and Moses in their roles of liberators of mankind. In this way he was establishing a bridge of identification to the biblical Abraham who was the father of his people. The themes of saving life and creating life reemerged, in a more grown-up setting, out of the original primitive rescue fantasy involving the mother

figure and the monster. The dynamic charge of what was originally an incestuous wish was now aided by identification with heroic figures from two traditions, propelling the young patient to find a new set of sublimations to reshape his character and to consolidate his identity.

Toward the end of the second period of treatment, when the patient had been doing very well in school and had discovered that he was unusually proficient in mathematics, a new figure began to occupy his fantasy life and to take its place in the growing world of Morris' values. This was the figure of Einstein, who epitomized to the patient how to use the intellect as an expression of power—a power that is turned to the advancement of science and to the betterment of mankind. The patient said that he didn't quite expect to be another Einstein, but he aspired to follow in his footsteps. This notion, while perhaps grandiose, was nonetheless a sublimated version of the impulse to grasp omnipotent power, a modern version of the quest for Prometheus.

From Dracula to Einstein one was able to follow in a series of progressive steps the interplay of two cultures, two separate traditions, that served to transform the primitive antisocial instinctive impulses of the child. This was done in successive stages of identification with the cultural heroes of the two traditions. By means of these identifications, changes in values were gradually effected, ego ideals were progressively transformed, the infantile conflicts were resolved, and the consolidation of the sense of identity began to emerge.

I have tried to demonstrate from the analysis of a neurotic child in the grasp of parental and cultural conflicts how the forces of tradition operate to facilitate selection of appropriate ego ideals and to prepare one for the consolidation of the sense of identity that takes place during the period of adolescence. An appropriate awareness of the role of these traditional elements is an essential feature in the psychotherapeutic interaction.

Peter B. Neubauer, M.D.

It would be naïve to assume that religious feelings and faith do not have a profound place in man in spite of his attempt to master nature and to establish his superiority. Freud's statement that "...the defense against childish helplessness is what lends its characteristic features to the ... formation of religion" (12) links the prolonged state of dependency of man to the need to establish

value systems that order human function in such a way as to safeguard the individual and his role in the group. Moreover, this state of dependency implies that the child will continuously look for outside power to protect him and to supply him with all those needs which will guide him through life.

Winnicott's transitional object—i.e., the capacity of the child to transfer to inanimate objects expectations oriented primarily to the parent and to endow these with qualities of safety, protection, continuity, and possession—is an important early psychic mechanism that one can link to religious phenomena. The question arises whether those children who show a prolonged history of employing transitional objects also show a special reference to their religious position, as compared with those in whom the primary relationship stays undiluted. Winnicott (13) explored the transitional phenomena with reference to mystery and mysticism, implying that at a certain stage of mother-child interaction the inner requirements are met for the emergence of these feelings.

We can also discuss the stage in which the child normally tends to evolve his own "rituals." They are most often connected with the social aspect of his life—his relationship to his parents and to his evolving self. Thus we see rituals connected with bedtime, toileting, or the process of separation, i.e., the leaving or return of the mother. Furthermore, we know how the eating scene can become endowed very early with ritualistic expectations: the preparation and selection of the food as well as the role of the mother during mealtime. According to Piaget's sequences and steps in the evolution of logic and time and space sequences, the evolution of these control systems toward an organized, to-be-anticipated and perpetuated form is initiated long before other cognitive systems are established. We are very much aware of the protective nature of these rituals against inner demands and aggressive strivings, as well as against fears of the loss of the parent's love. The ritual is thus a compromise phenomenon and has its special place in the development of the child. The exploration of the role of religion in the child's life will have to involve the study of the relationship between these normal rituals and those provided by religion.

In other words, what is the interaction between rituals that evolve out of inner need and

rituals that the religious family will bring to the child? What happens to the child when he observes his all-powerful parent deferring to another force greater than himself? Can we detect differences in influence among children who grew up with external rituals compared with those exposed to higher values without ritualization? At what time and in what form have the rituals tended to isolate feelings rather than promote them as a "tradition"?

Acceptance or Rejection of Traditional Values

Such questions imply the need to understand, within individual families as well as within the code of the specific religion, who is the model of values and how the father or mother transmits the tradition. Whether the child will accept or reject the tradition will depend on the child's relationship to the person who transmits it. Mahler's clearly delineated subphases of separation-individuation have a close relevance to this issue, for here we find the forerunners of the continuation of family behavior. In the process of the individuation of the child, the later continuation of the parental values will emerge. He may accept them by identification with the parent, or as a "condition" to be accepted for fear of the loss of the parent's love. We find here the matrix for the later phase of individuation during adolescence. The first years of life—with the exploration of dependency, magic feelings, and the establishment of symbolisms in the second year of life—gain importance for the establishment of beliefs and faith and the various aspects of religious functions. What follows next are significant expansions into new areas of psychic function and social interrelations.

This brief exploration does not permit reference to the succeeding stages of development as these are relevant to the evolvment of religious feelings or identification with a religion. However, I do want to mention that the negativistic phase against controls from the outside, as it occurs as part of the training phase of the second year of life, is in some form repeated during adolescence when individuality is formed, at times in opposition to the environment. Similarly, negative feelings against a system of values or religious beliefs are at times contributing factors in the creation of an inner-absorbed value system.

The evolution of the logical system of thinking during latency, with its demand for explanatory statements and causative principles, will have its special influence on the acceptance of belief systems.

During latency the child steps from the home into the peer group and finds forms of behavior that either confirm those of his family or contradict them. This confrontation may constitute an important challenge to the child. It is clear that in the various stages of adolescence, during which a *Weltanschauung* is formulated and expansions of a philosophical system are required, religious feelings again play a role in the life of many children. They may be either in opposition to the family tradition in order that the child can achieve a new individuality, or toward the family in order that the child can test new ideas and thoughts on a higher level of integration.

These are some examples indicating how one may follow the vicissitudes of the evolution of feelings of faith or beliefs. A developmental frame of reference will permit a clearer understanding of the general aspects of man's search for religion, as well as of the genetic components of religious conflicts.

REFERENCES

1. Freud S: Totem and Taboo (1913), in *Complete Psychological Works*, standard ed, vol 13. Translated and edited by Strachey J. London, Hogarth Press, 1955, p xv
2. Freud S: Address to Society of British Psychiatry (1926). *Ibid*, 1959, pp 271-274
3. Mead M: *Culture and Commitment: A Study of the Generation Gap*. New York, Doubleday & Co, 1970
4. Erikson E: *Identity: Youth and Crisis*. New York, WW Norton & Co, 1968
5. Conger JJ: A world they never knew: the family and social change. *Daedalus* 100:1005-1138, 1971
6. Balswick J: Are American Jewish families closely knit? in *The Jewish Family: A Survey and Annotated Bibliography*. Edited by Schlesinger B. Toronto, University of Toronto Press, 1971, pp 15-24
7. Rosenberg SE: *The Search for Jewish Identity in America*. New York, Anchor Books, 1965
8. Sklare M: Intermarriage and the Jewish future. *Commentary* 37:46-52, 1964
9. Aichorn A: *Wayward Youth*. New York, Alfred A Knopf, 1936
10. Sachs H: *The Creative Unconscious*. Cambridge, Mass, Sci-Art Publishers, 1942
11. Arlow JA: Ego psychology and the study of mythology. *J Amer Psychoanal Ass* 9:371-393, 1951
12. Freud S: *The Future of an Illusion* (1927), in *Complete Psychological Works*, standard ed, vol 21. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 5-56
13. Winnicott DW: Transitional objects and transitional phenomena. *Int J Psychoanal* 34:1-9, 1953

On the Bicentenary of the Birth of Esquirol (1772-1840), the First Complete Psychiatrist

BY GEORGE MORA, M.D.

On the 200th anniversary of Esquirol's birth, the author discusses his remarkable contributions to psychiatry in the areas of classification and symptomatology, therapeutic principles, teaching, and improvement of legislation concerning the mentally ill.

LIKE MANY OTHER 19th-century French psychiatrists, Jean Etienne Dominique Esquirol was born in southern France. His family was from Toulouse, where his father administered an institution in which epileptics, mentally ill persons, and delinquents were put together, as was the custom of the time. Apparently under the influence of his father's work, he felt motivated to be of help to others and entered a seminary for the priesthood, but he had to leave it soon because of the Revolution. He then studied medicine at the famous medical school of Montpellier, where he was influenced by liberal ideas. At the age of 24 he moved to Paris and became interested in the psychiatric institutions of the time, especially in the Salpêtrière, then under the direction of Pinel, whose favored pupil he became.

In 1805 he presented his thesis titled "Passions Considered as Causes, Symptoms, and Therapeutic Means of Mental Diseases," a theme that permeates his entire work and makes him a forerunner of psychodynamic theories and practices. In 1811 he was named a regular physician at the Salpêtrière, where his intelligence, sensitivity, and motivation soon came to be recognized. A few years later he founded a sanitarium in Paris for a small

number of mental patients; he himself lived among them. Also in 1811 he inaugurated the first official course on mental diseases for physicians and medical students. Having visited a number of institutions and gathered evidence on the poor conditions of the mentally ill, he sent a moving report of his experiences to the minister of the interior of France in 1818.

Three years later he also visited the famous village of Gheel, Belgium, where, for centuries, mentally ill persons had been boarded and employed by farmers. He proposed the introduction of periodic examinations of the inmate population in a proper facility run by competent physicians.

Named general inspector of the faculty of medicine at the Salpêtrière in 1823, two years later he left to become superintendent of the Maison de Charenton, which became famous for having housed the Marquis de Sade for a long period of time until his death. Shortly after Esquirol's election to the committee on public hygiene of the district of the Seine, he took a long trip to Italy to recover from overwork. While there he visited many mental hospitals and made suggestions for their improvement. In Rome, he learned of his nomination to the Académie Royale des Sciences Morales et Politiques. He devoted 15 years to the preparation of his textbook, *Mental Maladies* (1), which was immediately recognized as outstanding and was soon translated into German, English (2), and Italian. In 1838, after a long effort, the famous law for the commitment of mental patients was passed in France; it eventually became the model for similar legislation in all the Western countries. Esquirol died in 1840 at the age of 68.

Esquirol's Contributions to Psychiatry

From the description of his personality left

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by contemporaries, it is evident that Esquirol was a very unusual man. He was warm and extroverted but at the same time studious and methodical. He apparently had the ideal personality for a psychotherapist: he shared his life with the mentally ill, played music with them, and worked with them.

To facilitate an understanding of his many contributions to psychiatry, I will discuss Esquirol's work under several subheadings:

Classification and Symptomatology of Mental Diseases

Esquirol classified mental diseases into five groups: lypemania, mania (including monomania), melancholy, dementia, and idiocy.

Lypemania (accompanied by delusion) was thought to be often hereditary and characterized by immobility of the body, fixation of the eyes, and an expression of pain.

Mania was characterized by excitement of all the mental faculties, rapidity of perceptions, illusions and hallucinations, and errors of judgment.

Monomania (a word coined by Esquirol) was characterized by the prevalence of a delusion centered on a particular theme. Intellectual monomania was based on wrong convictions and faulty associations leading to delusions, affective monomania on apparently intact intellectual functions with disorders of character and behavior, and instinctive monomania on a deficient will, resulting in impulsive behavior of all kinds. Esquirol also gave a detailed description of erotic monomania, reasoning monomania, intoxication monomania, arson monomania, religious monomania, and homicidal monomania.

Melancholy was described according to the classical pattern of reduction of movement, restriction of emotional life, and a self-deprecatory attitude.

Dementia was characterized by a weakening of all the mental faculties. In its acute forms it was thought to have a good prognosis, while the prognosis for the chronic forms (especially in cases of general paresis) was considered poor.

Idiocy was considered a condition, not a disease, and congenital, in contrast to dementia, which was acquired. Idiots were to be separated from imbeciles, who were less retarded.

In the area of symptomatology, Esquirol is especially renowned for his distinction be-

tween hallucinations (true perceptions, like awakened dreams, without the intervention of the senses) and illusions (due to heightened, weakened, or perverted sensitivity of the nerve ends). He also correctly described postpartum psychosis and the somatic components that accompany psychopathology.

Etiology of Mental Diseases

Esquirol attributed mental diseases to a variety of causes: general and particular, physical and moral, primary and secondary, predisposing and facilitating. Heredity represents the most frequent predisposing cause, as in the case of children with mentally ill parents. External causes of various kinds, such as climate, are also mentioned; of the internal causes, he believed that vigorous intellectual pursuit did not necessarily lead to insanity. In terms of age at onset, the earliest period of appearance of some pathological conditions was puberty. Abuse of wine, liquor, and drugs, masturbation, faulty education, and, especially, deprivation of spirits and relaxation of mores as well as social upheavals were all considered conducive to mental disorders.

Above all, however, were passions: fear, dread, ambition, financial losses, family problems, and conflict between instincts and the principles of religion, ethics, and education.

Therapeutic Principles

Esquirol's therapeutic philosophy was based on the combined action of the therapeutic milieu of the institution and the use of "proper passions" to replace the disturbed ones. He stated that a mental institution in the hands of a skillful physician is the most powerful therapeutic agent against mental illness; the physician is the moving agent, the leader, and the authority in the institution; and great involvement and dedication are necessary to succeed in this field of medicine.

According to Esquirol, the physician, rather than relying on dogmatism, should establish the treatment regimen on the basis of his observation of the patient—his gestures, movements, appearance, actions, and imperceptible nuances. Believing that the mentally ill were like children who had been influenced by faulty ideas and education, Esquirol thought it unwise to base a therapeutic approach on reasoning. He recognized that at

times the patients were aware of the disorder in their intellectual faculties but were unable to modify their beliefs. The most effective approach, he thought, was to individualize the treatment for each patient and to use healthy emotions to reestablish the psychological health lost under the influence of the faulty emotions. To achieve this it was necessary to obtain the confidence of the patient: this, in itself, would ensure a rapid cure. The best way to accomplish this was for the doctor to get control of the will of the patient by fixing him with his eyes so as to elicit some fear in him, soon followed by encouraging words and gestures. Esquirol considered such an authoritarian but at the same time supportive attitude almost always sufficient to subdue even agitated patients.

A serene and varied milieu in the institution, consisting of pleasant conversation, physical exercises, and work, would also contribute to improvement. In certain cases violent emotions would have to be encouraged in order to counteract other emotions. Also, isolation could be beneficial by interrupting the course of the faulty emotions and the dangerous influence of family members and, following an initial period of fear of the unknown, by eliciting emotions related to the hope of gaining freedom in the future. "Perhaps one day," wrote Esquirol in his thesis of 1805, "it will be possible to establish the principles of a psychological treatment based on the knowledge of the primary disturbed idea, to which all disturbed passions are attached."

Teaching of Psychiatry

It is well known that the French school, based on clinical observations, constituted the backbone of 19th-century psychiatry. Esquirol, who was the only disciple of Pinel, soon realized that the new knowledge related to mental diseases had to be widely distributed. Throughout his professional life he lived in close contact with mental patients and shared his observations of their symptoms and the course of their illnesses with those around him. In 1817 he initiated the formal teaching of psychiatry, essentially based on clinical matters, at the Maison de Charenton.

For 15 years, from 1823 to 1838, he worked assiduously on the preparation of his textbook on mental diseases (1). When the work

finally appeared in 1838 in two elegant volumes accompanied by 27 lithographs, it was immediately hailed as a major contribution to the field of psychiatry. It was the first comprehensive work systematically divided according to the main clinical pictures. For each, the definition, etiology, clinical course, therapy, and outcome were clearly given. Moreover, it was the first book to apply statistical methods to clinical studies; i.e., Esquirol tabulated psychological causes, such as disappointment in love, financial worries, and similar factors. As Zilboorg has stated (3), Esquirol's figures are in themselves imposing and indicate the enormous mass of material the psychiatrist had at his disposal.

In view of such an accomplishment, it is no wonder that his textbook was soon translated into other principal languages. It served as the basis of the school of psychiatry that he founded and that numbered among its members such outstanding men as Guillaume Ferrus, Jean-Pierre Falret, Félix Voisin, Etienne Georget, Ulysse Trélat, François Leuret, Louis Calmeil, Jean Parchappe, Louis Lélut, Jacques Moreau de Tours, Louis Delasiauve, and Jules Baillarger, each well known for his contribution to psychiatry.

Improvement of Legislation Concerning the Mentally Ill

Throughout his entire life, Esquirol aimed at improving the condition of mental patients. He did not hesitate to undertake long trips at a time when travel was difficult and even hazardous to learn about systems of care and treatment. Also, rather than following commonly accepted opinion on certain practices, he tried to pass judgment on the basis of his firsthand observation. Typically, instead of accepting the traditional belief concerning the centuries-old family care for the mentally ill practiced in the Belgian village of Gheel, he visited it, studied that kind of practice, and suggested ways of improving it.

I have already mentioned the letter Esquirol addressed to the minister of the interior of France in 1818 in which he vividly described the horrible conditions of the inmates in many institutions in France. The renown he achieved in his field resulted in his appointment to several official positions, through which he was able to influence legislation toward improving these conditions.

To be sure, the situation was truly dis-

couraging. Prior to the Revolution of 1789, the mentally ill had been committed to institutions through a *lettre de cachet*—an order issued by the police and signed by the king. The institutions housed paupers, the crippled, defectives, delinquents, and mentally ill persons together. Following some little-known investigations of the situation and especially influenced by the urge toward social improvement brought about by the Revolution, Pinel introduced his famous reform of psychiatric care, first at Bicêtre and then at the Salpêtrière, the former an institution for severely sick male mental patients and the second for females.

While the situation improved in Paris, it remained disastrous elsewhere, to the point where it was difficult to decide whether institutions for the mentally ill were shelters or detention homes. With about 10,000 mentally ill persons throughout France affected, the central government became concerned. In his 1818 letter, Esquirol had recommended the creation of regional asylums, each housing not more than 150 patients who could remain there a maximum of two years, after which they would have to be placed in institutions for the incurable. The local administrations were to underwrite the cost of this program, while the overall supervision was to be exercised by the central government. Such a plan was in line with the philosophy of moral treatment introduced in England and in the U.S. around the same time, which anticipated by more than a century today's community mental health movement.

Unfortunately, because of political and other factors, nothing came of Esquirol's proposal, which was officially presented by him and other members of a specially created commission. In 1834 there were about 34 public institutions accepting the mentally ill, while 65 hospitals admitted mentally ill persons together with other patients. In the best institutions the mental patients were assigned to various sections depending on the degree of their pathology. The Maison de Charenton, which was run by Esquirol and is still in operation today, was the only facility for "curable" mental patients. A number of institutions were staffed and sponsored by various Catholic orders.

After many compromises, legislation concerning the mentally ill was finally passed in 1838 and remained in effect until recently. It

established a definite procedure for commitment of mentally ill persons throughout France: special forms were to be filled out and signed by competent physicians and then made official through court action; voluntary admissions were encouraged; and for each new patient there was to be a period of observation until a definite plan could be made for his treatment. Similar legislation was soon introduced in most other Western countries.

The Significance of Esquirol's Work

At this point, some comments are in order in regard to the sources of Esquirol's thinking, the significance of his work, and his position in psychiatric historiography. Traditionally, it has been held that Esquirol derived most of his thinking from his teacher, Pinel. While this is still accepted, increasing attention is being paid to other sources. In particular, the well-known French psychiatrist Henri Ey has stressed the similarities between Esquirol's views and those held by the German *Psychikern* school (Heinroth, Reil, and Langemann). These early-19th-century psychiatrists believed in the psychological etiology of mental disorders. Certain psychotherapeutic techniques, such as causing mental shocks, are described in similar terms by these authors and by Esquirol.

Common to all of them is the emphasis on the role of the passions, up to the level of emotional dissociation, in the etiology of mental diseases. Consequently, it was thought that artificial passions could be of help in counteracting normal passions. This method, which has been called by W. Riese the "instrumental use of passions" (4), can be traced back to the Aristotelian and Stoic schools, as clearly shown by Lain Entralgo (5). The concept of interrupting the normal associations of the patient, even through such a drastic means as an emotional shock, presupposes a dynamic view of the personality, in contrast to the partial but disconnected insights presented by the German *Psychikern*. Esquirol's idea that one day the central core leading through faulty associations to mental disorder would be discovered represented a clear anticipation of the psychoanalytic method as brought forward by De Saussure (6). On this basis, Esquirol's

view of the personality has been called "psychodynamic" by Ey (7).

Undoubtedly, however, the concept of monomania, probably introduced by Esquirol to overcome the confusion created by the use in French of *délire*, in English of "delusion," and in German of *Wahn*, constituted a major issue in a good part of 19th-century psychiatry. It was described by Esquirol as a partial or symptomatic delusion that appeared clinically as a logical outcome resulting from faulty postulates and related to the unfolding of the constitutional make-up of the personality in the context of experience.

With the refinement of symptomatological understanding from the mid-19th century on, monomania was viewed in its connection with "moral insanity" (described by Prichard) and later as a symptom of paranoia, in its traditional meaning. The issue was then raised as to whether monomania represents a primary or secondary symptom, that is, whether the delusion is an expression of a passion that forms itself in the inner core of the person and is projected into existence or whether it is an expression of a restitutive phenomenon.

No matter what position one takes, the fact remains that the concept of monomania became important, mainly in relation to legal psychiatry, in the first part of the 19th century, as shown in the extensive review by De Saussure (8). The concept was widely debated, especially in regard to the issue of total and partial irresponsibility in judicial trials of supposedly mentally disturbed people.

Finally, Esquirol's contribution to psychiatry is well recognized both in France and elsewhere. However, only two comprehensive studies of his life and work, by Semelaigne (9) and more recently by Ey (7), are available. Other specific mentions are made in the studies of De Saussure (10), Bolotte (11-13), and, in this country, by Amdur and Messinger (14). In addition, of course, sections have been devoted to him in general histories of psychiatry (3, 15-21).

It is clear that Esquirol, although less pioneering than Pinel, surpassed him in the depth and breadth of his views, which encompassed the whole field of psychiatry. For this, it seems justified to call him "the first complete psychiatrist." Today, two centuries after his birth, a thorough study of his life and work in the light of modern psychiatry is needed.

REFERENCES

1. Esquirol JED: Des maladies mentales, 2 vols. Paris, JB Baillière, 1838
2. Esquirol JED: Mental Maladies: A Treatise on Insanity (1845). Translated by Hunt EK. New York, Hafner Publishing Co, 1965
3. Zilboorg G: A History of Medical Psychology. New York, WW Norton & Co, 1941, p 390
4. Riese W: Introduction and interpretation, in Galen on the Passions and Errors of the Soul. Translated by Harkins PW. Columbus, Ohio State University Press, 1963, pp 1-21, 111-131
5. Lain Entralgo P: The Therapy of the Word in Classical Antiquity. Translated by Rather LJ, Sharp JM. New Haven, Yale University Press, 1970
6. De Saussure R: La psychothérapie d'Esquirol. *Evolut Psychiat* 4:53-67, 1939
7. Ey H: J.E.D. Esquirol, in *Grosse Nervenärzte*, vol 2. Edited by Kolle K. Stuttgart, Thieme, 1959, pp 87-97
8. De Saussure R: The influence of the concept of monomania on French medicolegal psychiatry (from 1825 to 1840). *J Hist Med* 1:365-397, 1946
9. Semelaigne R: Les pionniers de la psychiatrie française avant et après Pinel, vol 1. Paris, JB Baillière, 1930, pp 124-140
10. De Saussure R: French psychiatry of the 18th century. *Ciba Symposia* 11:1222-1252, 1950
11. Bolotte G: Les projets d'assistance aux malades mentaux avant la loi de 1838. *Information Psychiatrique* 41:505-513, 1965
12. Bolotte G: Les projets d'assistance aux malades mentaux sous la Restauration. *Ann médicopsychol* 124:383-401, 1966
13. Bolotte G: L'assistance aux malades mentaux à Paris de 1789 à 1848. *Ann médicopsychol* 124:463-474, 1966
14. Amdur MK, Messinger E: Jean-Etienne-Dominique Esquirol. *Amer J Psychiat* 96:129-135, 1939
15. Bromberg W: Man Above Humanity: A History of Psychotherapy. Philadelphia, JB Lippincott Co, 1954
16. Schneck JM: A History of Psychiatry. Springfield, Ill, Charles C Thomas, 1960
17. Leibbrand W, Wettley A: Der Wahnsinn. Geschichte der abendländischen Psychopathologie. München, Alber, 1961
18. Kraepelin E: One Hundred Years of Psychiatry (1921). Translated by Baskin W. New York, Citadel Press, 1962
19. Alexander FG, Selesnick ST: The History of Psychiatry. New York, Harper & Row Book Co, 1966
20. Baruk H: La Psychiatrie française de Pinel à nos jours. Paris, Presses Universitaires de France, 1967
21. Ackerknecht E: Short History of Psychiatry, 2nd ed. Translated by Wolff S. New York, Hafner Publishing Co, 1968

DISCUSSION

RUBEN D. RUMBAUT, M.D. (Houston, Tex.)—A paper like this confronts the discussant with the historical figure, Jean Etienne Dominique Esquirol; the historian author, Dr. George Mora;

and the subject matter, the history of psychiatry.

Esquirol, the historical figure, came alive to us as a "complete psychiatrist" formed by an extraordinary number of different facets: a pioneer, a writer, a teacher, a founder, a reformer, a clinician, a statistician, a public health officer, a capable administrator, a forensic innovator. He was not solely a quiet, persevering, and accurate observer of clinical symptoms, taking daily notes and pouring them into articles and textbooks; he also assumed great responsibilities, created with his mentor Pinel a new school of psychiatric thought in France, and challenged in due time the status quo by vigorously denouncing the horrible conditions he saw in the great majority of the asylums of his time.

In this role, particularly appealing for its combination of courage, compassion, and constraint, he was indeed a true man of science but not of the cold, detached, and uninvolved type. One is reminded, in reverse, of what Unamuno said about Anatole France: "I don't like him, because he does not know how to become rightfully indignant." Esquirol knew how, where, and when to become rightfully indignant; thus his official report to the minister of the interior about the sordid French asylums shook up the inept and ignorant bureaucracy of the country, initiated a widespread movement for reform, and eventually evolved into model legislation protecting the rights of the mentally ill. That piece of legislation inspired all the others that have come after it in our Western civilization, even up to the present.

Esquirol is the man who once wrote: "One has to love the mentally ill in order to be worthy and capable of serving them," a motto preached with his own example: he lived serenely among patients, disciples, students, and employees. One of his pupils even wrote that he "never engaged in in-

trigue nor participated in a cabal, never displayed jealous rivalry, never suffered inner agony when a competitor won over him. He has seen enemies on occasion attack him relentlessly, and he has forgiven them. He has seen pupils he has loved turn against him, and he has not loved them the less" (1).

Dr. Mora, modern historian, scholarly and quixotically keeps alive year after year the flame of the history of psychiatry in the pages of *The American Journal of Psychiatry*, in other periodicals, and in books. There is no question that his persistent work is already positively influencing our field, helping people understand psychiatry as a process rather than a "happening."

This takes us finally to the subject matter: the history of psychiatry. From being ridiculed, ignored, or simply tolerated, gradually it has become a respectable discipline, seriously taught in numerous medical schools and an indispensable part of the professional knowledge of any well-trained and educated psychiatrist. If the child is father to the man, the psychiatry of yesteryear is the mother of our present-day specialty. One cannot adequately understand a man without getting to know the child that he was; by the same token, one cannot understand modern psychiatry without knowing its complex, laborious, difficult beginnings. Unfortunately, resistances and prejudices about its study in depth are still widespread and tenacious. George Santayana, in a well-known dictum, stated that those who ignore history are condemned to repeat it. But what can we do with those who ignore Santayana?

REFERENCE

1. Leuret F: quoted in *Humane psychiatrist*. MD 16(2):166, 1972

Subcontracts for Community Development and Service

BY HARVEY M. FREED, M.D.

Subcontracts for certain services were awarded two years ago by an inner-city community mental health center to two community organizations that seemed to exemplify the growing spirit of pride that was emerging in the black community. The author describes the problems that developed, especially in regard to recruiting and retaining professional personnel, and the approaches to their solution. There have been both failures and successes: prevention programs have not yet taken hold, but the parent organizations have become more responsive to community needs.

APPROXIMATELY TWO YEARS ago a large urban community mental health center (CMHC) subcontracted part of its service to two neighborhood community organizations serving a population of about 25,000 black people from the CMHC's total catchment area of 125,000. The process leading to the development of the subcontract has been described elsewhere (1). In brief, it was a political decision in response to pressure from the two organizations in a series of confrontations that took place between June 1968 and June 1969. It was also in keeping with the program's strong commitment to community development (2).

At this point, it is necessary to attempt to evaluate the two years' progress: What has been the outcome of the subcontract arrangement? Thus far several factors have

mitigated against a definitive statement. First, in the heat of the negotiations of two years ago, and in the face of the political complexities, no concrete long-range goals and objectives were specified. Second, the two organizations have retained considerable autonomy—have even maintained some isolation and secrecy about their operations—and thus evaluation has been difficult. Third, this is a process still in evolution. While an attempt will be made to view it in perspective, there is the danger that the result will be a cross-sectional view because two years may be insufficient time in which to evaluate the developing concept of "community control."

The community in question, which we will call "West Side," consists of about 25,000 people, almost all of whom are black. While it is part of the city's west-side black ghetto, it is somewhat isolated by virtue of the presence of a Mexican neighborhood to the south and an urban university and large medical center to the north. The university and medical center are slowly invading West Side's borders via expansion of their facilities, displacing residents into other marginal areas of the city. West Side tends to be a port of entry for blacks migrating from the south (especially from Mississippi). By all statistical indices it is very poor. The men of the area are victims of heroin addiction, alcoholism, and crime (a persuasive argument has been presented about crime's being an adaptive response to local conditions by men who are aggressive and active [3]). While the resident agencies provide some service, they do not attempt to tackle the major social problems facing the community. The development of the two community organizations is becoming a significant influence in this area.

The Two Organizations

The first community organization was

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started in the early 1960s by a city-wide religious society. Although originators of the project included white and black members, the white ministers early took a back seat in an effort to promote the development of local leadership. Four black men, all ex-convicts, formed the nucleus of this group. A conflict with a local laundry brought it prominence and set its stance as militant. In the last six years it has developed expertise in the housing and welfare systems and has helped numerous citizens to obtain better service, using a combination of threats, knowledge of the local community and of the law and bureaucracies, persistence, and political "clout." It has also offered help with job placement. A major focus, however, is economic development: the organization now manages a Shell station, has a McDonald's hamburger franchise, owns a paper processing plant, and has increasing real estate holdings. In this paper we will call it "West Organization."

The other organization, here called "Black Students," is of more recent vintage; it began in the mid-1960s. Composed of younger men, it is led by a charismatic and charming but also controlling and explosive leader. Although it was initially affiliated with and supported by the YMCA, the latter organization has since severed the ties. The nearby medical school has developed a neighborhood health center in collaboration with Black Students; this is located adjacent to the mental health offices in the same building. While both groups prefer separate identities, they respect each other and cooperate in certain ventures. In cooperation with three other West Side organizations, they have formed a corporation designed to promote economic and social endeavors.

The CMHC program, on the other hand, had a major commitment to the development of the community. In that context it was felt to be important to support and attempt to strengthen the two neighborhood organizations that seemed to best exemplify the growing spirit of pride and achievement emerging in the black community. It was hoped that giving the subcontracts to the two organizations would strengthen them by their acquisition of additional resources, would further legitimate them by their relationship with the CMHC and by their function in performing additional service for the community, and would encourage them by their suc-

cess in entering a social system formerly closed to them. Their participation would undoubtedly have a salutary effect by helping to "open up" that system and would demonstrate that nonprofessionals could be trained to provide effective mental health services. The two organizations would then be encouraged, we hoped, to recognize the need to broaden their base of support in the community.

There are two central hypotheses here that were being put to the test. The first is that effective services can be provided by such community organizations. The second is that the subcontractual approach can promote community development. What has happened thus far? Much of the argument about the provision of effective services hinged on the idea that nonprofessionals from the neighborhood could be trained to serve as mental health counselors. Thus far our experience has been mixed: While the counselors were often effective in obtaining concrete services for their clients such as food, housing, missing welfare checks, etc., they tended to overlook, not to understand, or to underestimate the significance of psychological forces. Problems were often seen as the result of social factors, and those with a strong reality component were handled well. More subtle emotional problems were often missed.

Obviously disturbed patients were quickly referred to the professionals or to the center, under the rationale that the counselors were "not equipped" to deal with them. Underlying this was the not-so-disguised fear of the unpredictability or potential violence of patients and the feeling that the problems of mentally ill people were not as much of a priority as those of other groups. "People need jobs," goes the refrain, "and not social programs." Counselors sometimes expressed resentment that professionals would see some people for extended periods of time and would provide them with medication. This was seen as fostering too much dependency, a practice that was inimical to the goals of the organization.

On the other hand, such attitudes were not universal. Some counselors were clearly psychologically minded and empathic; they were very helpful to people whose problems had a strong psychological component. Many patients looked forward to their appointments with the counselors and particularly liked the

fact that they could drop in at unscheduled times and receive service. In addition, the counselors were much more willing than professional staff members to go to patients' homes, to accompany them to other agencies, to intervene on their behalf with bureaucracies, etc.

Attempts have been made to develop training programs for the counselors, but none of these has been successful. Working side by side with professional staff has probably been the most effective training measure, but its effectiveness has been lessened to some extent by turnover in both professional and nonprofessional staff and by changes or conflicts in program policies. There has also been a strong bias against education, more so among the older staff of West Organization than among Black Students. Comments like "We know how to work with these people because we've been living here all our lives" were common. One of the additional constraints against training seemed to be the fear of losing well-trained staff who would seek advancement elsewhere. And one of the disadvantages of the subcontract system seemed to be that the relatively small number of staff provided for by the subcontract allowed for very little advancement within the system.

In spite of this, it is notable that more than half of the counseling staff of the two organizations have remained with the program for the two years of its existence. Part of the reason for this relates to a possible explanation for the difficulty in effecting training. To a greater extent than in professional systems, jobs in these programs are patronage rewards. Staff members are selected as much for their loyalty to the organizations, or because of need, as for qualities or characteristics deemed essential for mental health counselors. Experience elsewhere has shown that nonprofessionals may become effective mental health workers if they are highly selected, well trained, and well rewarded for their efforts. In this situation, however, different criteria for the selection of staff have prevailed, and the provision of training and rewards has posed complex problems. Experience elsewhere has also shown that some people selected to work in mental health programs become effective counselors while others are better at community work.

The two organizations cited here have rec-

ognized this from their own experience and have moved to alleviate some of the problems cited by developing a division of labor among their staffs. In both instances some staff members have been delegated the responsibility for working with "mental patients," while others stick to job placement, working with welfare or housing, etc. In our experience those people who have gravitated toward working with patients seem more psychologically minded than their colleagues. In that connection it should be mentioned that since the organizations have other responsibilities and programs besides mental health, *all* staff members, including the mental health counselors, may sometimes be drafted to fill or deliver Christmas baskets, dispense lunches, sell tickets to benefits, etc. Occasionally this has depleted the entire mental health staff and has forced patients to wait or to return for service at a later date.

Professional Assistance

It was recognized from the beginning that the programs would need professional assistance. Both organizations resisted using the money allocated to them to buy professional time because of the resistance to professionalism in general and because two or even three nonprofessionals could be hired for the price of one professional. The first contract called for at least one "professional" mental health worker to be hired by each of the two organizations in addition to the half-dozen or so counselors. Additional professional staff were to be available from the CMHC as needed. In practice, during the first year the organizations were unable to recruit qualified professionals and by agreement with the director of the CMHC settled for people with B.A. degrees as their "professionals." The CMHC provided a senior psychiatrist to each organization for approximately one hour a day plus a few additional hours a week, together with an experienced social worker to conduct training. While the training was unsuccessful, as already mentioned, the clinical services and on-the-job training provided by the psychiatrist were generally well received. The first year ended with both organizations requesting more professional time.

In addition, the two CMHC professionals, both especially gifted (albeit white), were able to provide a great deal of information to the

organizations and to the CMHC and to assist in establishing better linkages between the two. They both knew whom to call to get things done and consistently encouraged the mutually suspicious parties to meet together to resolve differences. As a result of their experience it was decided that both organizations should be enabled to hire their own professionals the following year. As outsiders the professionals had been distrusted to a great extent and their impact was thus limited. It was hoped that professionals responsible to the organizations would not be so suspect and would help bridge the gap between professional and lay values and concerns, black and white concerns, and CMHC versus organizational concerns.

Therefore additional funds were provided to each organization in its second annual contract to hire one fully qualified mental health professional plus a part-time psychiatrist. West Organization, which had been more critical of professionals in general, made yeoman efforts to hire black professionals, narrowing their range of choice considerably because of their insistence that the staff be black. Black Students, not as particular about race, made some efforts at recruitment, but these were not as persistent. By contacting every school of social work in the metropolitan area and several professional organizations and training programs for other professional disciplines, and by writing letters to every black psychiatrist in the city, West Organization finally located two professionals. One was a second-year social work student who would work full-time by arranging her work schedule so as not to interfere with her classwork. The other was a well-qualified community psychiatrist who would come in two half-days a week. Both were black. Black Students was never successful in recruiting professionals and again had to settle for people with B.A. degrees. I note all of this in detail to point up the need to contend with the real difficulties in recruiting professional staff to work in such organizations.

The impact of the professionals at West Organization was especially strong. Both professionals there spent considerable time establishing trust with the organizations and clearly had to identify with them. They came to be relied on heavily for program planning and for service to patients and soon began to feel overloaded. They have planned an ambi-

tious training program for counselors working with patients, are seeking funding and links with nearby educational institutions, and hope to begin training soon. Their presence has helped to define not only what West Organization's mental health program is prepared to undertake, but also what it cannot do at this time.

Perhaps most importantly, both professionals have agreed to stay on for the third year of the subcontract. The psychiatrist has been instrumental in recruiting another black psychiatrist to come in for three half-days a week, while he will move over to assume the medical directorship of a newly funded drug abuse program sponsored by the organization. Linkages with the CMHC have improved but are still not as good as those with other neighborhood outposts under direct control of the center. The wish of the organizations to be autonomous—to plan by themselves, etc.—remains most important, and both professionals identify strongly with this desire. At Black Students, the relationship with the CMHC has improved considerably, probably more than at West Organization; but this is partly because the relationship was much worse in the beginning.

It should be mentioned that there are many residents of West Side who will not use the services of the two mental health programs for a variety of reasons. Some fear the organizations' reputations for militancy and criminality; some know the staff members and do not want to be identified as needing mental health services; and still others do not know that professionals are on the staffs of (or are available to) the two programs. On the other hand, satisfied customers are "spreading the word" and there is some talk in the community about the growing success of the operations.

Weakness of Prevention Programs

What about other programs of a preventive nature, such as consultation, services to children, and special programs such as alcoholism and drug addiction? In general the preventive programs have not taken hold. While they have often been discussed, and sometimes even planned, few have been carried out. To some extent the organizations question the value of these programs. Again they stress the importance of jobs and belittle the

effects of social programs in general. Beyond that they question their ability to have an impact on social systems such as the schools—partly because of their own limited training but more importantly because they feel that the schools and other educational and social welfare institutions (particularly those related formally to the city administration) are too tightly run to be bothered with. In addition, they consider programs in areas that we consider preventive, i.e., housing, jobs, welfare, which were their *raison d'être* even before the CMHC came along, to be their province and are not particularly inclined to share their own planning or operations in those areas with the CMHC. As for children's programs, neither organization is inclined to do much in the way of formal mental health programming for children, partly because of the priority placed on making the adult community productive, partly because of lack of know-how, and partly because the CMHC has a team of staff members from its Children's Institute that works in West Side. Informally, however, the organizations run Neighborhood Youth Corps programs in the summer, have periodic picnics, sponsor athletic leagues, have pool tables available for children, show movies, and so on. Black Students does more of the latter, in keeping with its origin as a YMCA-supported program.

Alcoholism and drug abuse deserve special mention. While consultation programs or discussion groups about mental health issues seem somewhat ephemeral to the organizations, alcoholism and drug abuse, particularly heroin addiction, are very serious problems and ones that drain off potentially productive resources from the community. From the beginning these were noted as important issues and have repeatedly been cited as the outstanding mental health problems in the neighborhood. Members of the two organizations, as well as friends, neighbors, and relatives, have succumbed to drug addiction and alcoholism—evidence of very real problems in West Side.

West Organization, encouraged by the CMHC director, began to take an interest in the heroin problem and to plan a program to deal with it. Resources were scrounged from a number of sources and a temporary program was put together. First patients were detoxified in a few beds borrowed from the CMHC inpatient unit; when this program failed, an

outpatient methadone maintenance and detoxification program was started. The long-range goal was to seek funding to put the program on a more solid footing. From the beginning, there was strong community support. For 20 months, beginning in the fall of 1969, planning for the additional funding and expansion and development of the existing program proceeded simultaneously.

The process was often very stormy in that potential funding sources wanted tight medical control of the program, while West Organization insisted on greater community control. Numerous agencies at all levels of government and many private foundations were approached, to no avail. In addition the developing program posed serious problems for the hospital that was providing space and resources to keep the program alive. The unorthodox, often aggressive behavior of the addicts and the organization's staff wreaked havoc on institutional policies and attitudes. Also, the political problem of having a black community organization develop a program to serve the addicts of a broader catchment area that included many Chicanos and Central European residents in its farther reaches was a nightmare—probably the most serious problem in the CMHC's history. In the end, fortunately, West Organization was able to obtain funding for the program, which began on July 1, 1971, and is to continue for three years. Currently the organization is negotiating agreements with the CMHC and the state drug abuse program to support and enhance its newly funded program.

The pride that the addicts, the staff, the organization, and some members of the community have taken in the program is substantial. What sometimes seemed like insuperable obstacles were overcome and the program was finally put on a solid footing. While at times the disappointments and travail increased the distrust between West Organization and the CMHC, in the long run the relationship seemed to be enhanced by the need to work together at the task. Potentially far more important than the relationship with the CMHC, however, is the benefit that the program can bring to the organization's relationship to the community.

This leads us to note the salutary effect the organizations have had upon the CMHC and the medical center of which the latter is a part. This was an anticipated benefit, al-

though secondary, and has been very real. Pressure from the organizations has been responsible for beneficial changes in institutional policies and attitudes toward the populations served; community mental health in general has also benefited.

Impact on Community Development

Finally we need to examine the program's impact on community development. While this approach was based on the premise that promoting community development does have a positive effect on mental health, the merits of that argument cannot be pursued here. By community development we simply mean greater participation by community residents in planning *that is successful in helping them to achieve desired ends*. The latter is an important aspect of the concept: planning that is unsuccessful in achieving an end can be frustrating and disheartening to the participants, no matter how many people are involved in the planning process. West Organization has consistently opposed the concept of advisory boards, for example, on the grounds that the diffusion of authority and responsibility that would ensue from having to answer to such a group would hamper their ability to wrest badly needed resources away from other groups in the highly competitive urban scene. Their answer to the critics who charge them with substitut-

ing one form of domination for another is that at least they are successful in gaining resources that benefit the community.

The CMHC program is, nevertheless, putting pressure on both organizations to develop advisory boards and thereby to broaden their base of participation in the community. The fact that their two years of effort brought the organizations additional resources, an additional service role in their relationship with their communities, planning successes such as the drug abuse program, etc., seems to have increased their legitimacy to some extent, both in the neighborhood and in the city at large, and should bring beneficial results to their communities. To the extent that they can now actually broaden their base of participation and yet not hamper their effectiveness and viability as organizations, the goal of community development will be approximated even further.

REFERENCES

1. Freed HM, Schroder DJ, Baker B: Community participation in mental health services: a case of functional control, in *Mental Health in Rapid Changing Society*. Edited by Miller L. Jerusalem, Israel, Jerusalem Academic Press, 1972, pp 97-109
2. Freed HM, Miller L: Planning a community mental health program: a case history. *Community Mental Health Journal* 7:107-117, 1971
3. Ellis WE: *White Ethics and Black Power*. Chicago, Aldine Publishing Co, 1969

Adolescents in Crisis: Evaluation of a Questionnaire

BY ALVIN YUSIN, M.D., RUTH SINAY, PH.D., AND KAZUO NIHIRA, PH.D.

This paper presents data from a crisis evaluation questionnaire administered to 50 adolescents admitted to the Los Angeles County-University of Southern California Medical Center. Analysis of the questionnaire delineated four crisis behaviors—suicidal, aggressive, psychotic, and psychotic-drug—as the reasons for hospitalization. Each behavioral group was evaluated in terms of life situation areas covered by the questionnaire. Analysis of results identified characteristic life situations for each group, which could be used to differentiate the four groups.

THE PURPOSE of this paper is to present data from a Crisis Evaluation Questionnaire (CEQ) that assessed crisis behaviors and life situations for an adolescent population admitted to Los Angeles County-University of Southern California Medical Center from July 1969 to February 1970. Crisis behaviors were defined as those behaviors which directed an agency (family, police, school, or the adolescent himself) to seek immediate hospitalization for the adolescent patient.

Adolescent patients admitted for crisis behaviors are housed on a crisis ward. Each month approximately 30 patients between 12.5 and 18 years of age are admitted to this ward for a maximum stay of two weeks. Every other patient admitted to the ward received a CEQ. There were 50 subjects (25

girls and 25 boys) in the study, which ran from July 1969 to February 1970.

Method

We assumed that the adolescent initiated crisis behaviors when his or her emotional equilibrium was disrupted by stressful life situations. We attempted to evaluate crisis behaviors and life situations in the adolescent through use of the CEQ.

The CEQ consisted of 64 questions.¹ Eleven questions assessed the crisis (i.e., historical data about the crisis and patient reactions to it); 12 assessed family interactions, including parents' reactions to crisis; 17 assessed school performance, including historical information and reactions to school; seven assessed peer relationships; eight assessed drug use, including medical problems; three assessed the patient's relations with authorities; and six assessed the patient's sexual adjustment. Some of the questions required only "yes" or "no" responses, but most of them had multiple response categories.

Analysis of the 50 completed questionnaires delineated three distinct behavioral categories of crisis behaviors: suicidal behavior, defined as gestures and attempts to take one's life; aggressive behavior, defined as attempts to injure persons and/or property; and psychotic behavior, defined as delusions and hallucinations.² Closer examination of the questionnaires and hospital records of those individuals with psychotic behavior showed that they fell into two different categories: those individuals whose psychotic behavior was the result of drug abuse and those

¹ Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1-5, 1972.

At the time this work was done, Dr. Yusin and Dr. Sinay were with the Los Angeles County-University of Southern California Medical Center, where Dr. Yusin was Director of the Adolescent Crisis Unit and Dr. Sinay is Director of both the Child-Adolescent Psychological Services and the Child-Adolescent Psychological Training Program. Dr. Yusin is currently Assistant Professor of Psychiatry, University of Southern California School of Medicine, Los Angeles, Calif. 90033. Dr. Nihira is Assistant Professor of Psychiatry and Psychology, Neuropsychiatric Institute, University of California at Los Angeles.

² A copy of the questionnaire is available from the authors upon request.

³ People who brought adolescents to our units were not sophisticated in the use of psychiatric indicators for psychosis, and apparently delusions and hallucinations were the manifestations of the psychotic process that alarmed them sufficiently to seek immediate psychiatric hospitalization.

individuals whose psychotic behavior was not the result of drug abuse. With these behavioral indicators, four distinct crisis groups emerged: the suicidal group ($N=15$), the aggressive group ($N=11$), the psychotic group ($N=15$), and the psychotic-drug group ($N=nine$).

Analysis of Data

Each behavioral group was evaluated in terms of the life situation areas listed on the CEQ. This information was tabulated. Separate analysis of each response category, using one-way analysis of variance, indicated that the means of the four groups were significantly different, ($p<.05$ or less) for 19 response categories.³

Results

Statistical analysis delineated significant items that differentiated the four crisis behavior groups. These items further delineated the distinguishing characteristics of each group. The items are grouped according to the subgroups of the CEQ, i.e., crisis behavior, family relationships, school performance, peer relationships, drug usage, relations with authorities, and sexual relationships. This section includes only those subgroups which describe distinguishing characteristics for each group.

Suicidal Group

Crisis behavior. The crisis behavior of this group involved a suicidal attempt or gesture; it was frequently associated with the loss of a significant person such as a parent, friend, or sibling. These individuals usually felt sad at the time of crisis.

Family relationships. Parents of suicidal patients, compared to parents of children in the three other groups, showed the lowest incidence of a reaction (i.e., anger, worry, fear, or confusion) to the crisis, or to drug use if their child took drugs. They were the least concerned about their children exhibiting socially acceptable behaviors. Their method of disapproving of their children's behavior was primarily silence and withdrawal. They were the least likely to resort to any form of physical punishment, to expect obedience, or

to want more effective communication with their children, and they were not likely to contact a psychiatric facility about the crisis.

School performance. Those suicidal patients not in school had done nothing about getting back into school and disliked school because they were bored.

Peer relationships. The suicidal group had more friends (one to five) of the same age than did the other groups. Of those individuals in this age group who had no friends, the reason cited most often was fear of getting close to people. This group was the least interested in becoming leaders in peer groups (i.e., church groups, gangs, Scouts).

Drug usage. This group used drugs (i.e., barbiturates, marijuana, hashish, and heroin) far less than did the other groups. The few suicidal patients who did take drugs most commonly used amphetamines. Our sample, however, was extremely small, and this information may not be statistically significant.

Aggressive Group

Crisis behavior. Crisis behavior for this group involved the attempt to injure other persons or property. The crisis for this group occurred least often in the community, when compared with the other groups, and drug abuse was least often reported as the reason for the crisis. Most of the individuals in this group felt their crisis behavior was justified, and they were the least ashamed of this behavior.

Family relationships. Parents of this group of patients were most often angry about the crisis behavior and, if their child took drugs (only 36 percent did), were angry about the drug use. Although they readily discussed feelings of love and hate, these parents more frequently used physical punishment to show their disapproval of their child's behavior and they expected obedience from their child to a greater extent than did parents of children in the three other groups. They least often used silence and withdrawal as a means of punishment. They were not likely to contact a psychiatric facility when crisis behavior occurred and were least likely to want their child to have a college education.

School performance. Those individuals in the aggressive group who were out of school did nothing to return to school. Their grades

³ A list of response categories, means, and f ratios is available from the authors upon request.

were least likely to be above average. Some were bored by school.

Peer relationships. Individuals in this group who had no friends believed it to be due to their peers' disliking them. They did not wish to be leaders in peer groups.

Medical problems. A small percentage of this group had medical problems that contributed to the crisis. Parents responded to these problems by overprotecting the child. The patient sample, however, was so small that this information merely reflects possible trends and is not statistically significant.

Relations with authorities. This group did not get along with authorities and provoked them.

Sexual relationships. These individuals showed the least interest in the opposite sex; masturbation was never cited as the primary sexual release.

Psychotic Group

Crisis behavior. Crisis behavior for the psychotic group involved reporting delusions or hallucinations to others. This group showed a preponderance of low mean ratings. Neither object loss nor drug abuse was related to the crisis behavior. These individuals least often felt that their crisis behavior was justified, but they never felt sad about it.

Family relationships. Their parents were least likely to discuss angry feelings. They punished by silence and withdrawal and did not expect their children to communicate more effectively.

School performance. This group was the largest one with just-average school grades. Those individuals who were out of school had done nothing about getting back into school.

Peer relationships. These individuals most often had no friends their own age.

Psychotic-Drug Group

Crisis behavior. Crisis behavior for the psychotic-drug group involved telling others about delusions or hallucinations that were associated with drug use within 24 hours prior to admission. The crisis behavior most often occurred in the community. This group usually was ashamed of its crisis behavior.

Family relationships. Parents of children in this group blamed the crisis behavior on drugs. They felt sad about the drug problem and of all parents in the study were the most likely to contact a psychiatric facility for help

with the crisis. They, more than the other parents, expected socially acceptable behavior, wanted their children to go to college, and were angry if their children were not attending school. They also wanted to communicate more effectively with their children, yet they had more difficulty than the other parents in expressing feelings of love and hate. Their children used silence as a means of disapproving of their parents' behavior.

School performance. This group had the greatest number of patients with above-average school grades.

Peer relationships. The individuals in this group had friends and aspired to be leaders in peer groups.

Drug usage. The drugs used by these individuals included LSD, barbiturates, marijuana, heroin, and amphetamines. The primary reason they used drugs was to forget their problems.

Relations with authorities. This group got along well with authorities and was the group least likely to provoke them.

Conclusions

This information on individual behavioral groups led us to formulate the following generalizations.

The suicidal group seemed to be an unhappy, uninvolved group of adolescents who wanted human relationships, yet did not seem to have a sufficient number of them. Parents of these adolescents seemed indifferent to their children's problems.

The aggressive group seemed less mature and more impulsive than the other groups. Their parents seemed to serve as models for aggressive and impulsive behavior, yet demanded controlled behavior in their children.

The psychotic group seemed to be more detached from their environment, both physically and interpersonally, than the other groups. Their parents also seemed detached from their children.

The psychotic-drug group seemed to be a more intact group of adolescents who, along with their parents, were more socially aware than the other groups. Their crisis behavior seemed to be a disruption of a relatively stable previous life-style as compared to the other groups. Their parents, more than the parents of adolescents in the three other

groups, seemed to have attitudes toward their youngsters that reflected middle-class values.

Our information suggests that certain combinations of life situations may produce sufficient stress on adolescents to cause them to initiate four "crisis behaviors," i.e., suicidal, aggressive, psychotic, and psychotic due to drugs. These combinations of stressful life situations differed from one group to another. It was our assumption that some of these situation combinations could be used to determine the probability of the initiation of one of these four crisis behaviors.

Application of a stepwise multiple discriminant analysis enabled us to identify a set of six critical situation factors that helped to differentiate the four crisis behavior groups. They were use of hashish or heroin, lack of close friends and feelings that peers do not

like him/her, object loss, physical punishment by parents to communicate disapproval of patient's behavior, being out of school and doing nothing, and parental expectation that the patient have a college education.

The weighted combination of the information on these selected variables correctly classified nearly 80 percent of the subjects into the four criteria groups. Just as any other statistical prediction, this result requires further verification, employing independent samples of similar subjects and the acquisition of information on a normal control group. However, the result of the statistical analysis suggests that the combination of critical situational factors could be used to predict an adolescent's chances of initiating one of the four crisis behaviors described here.

Continuing Education for Community Psychiatry

BY LOUIS F. RITTELMAYER, JR., M.D., ROBERT G. KVARNES, M.D.,
AND IRVING SCHNEIDER, M.D.

The authors describe what is probably the first example of the joining together of all the psychiatric teaching institutions in a metropolitan area to sponsor a teaching program in psychiatry. Involving more than 400 mental health professionals in its seven years of existence, this program includes seminars and a practicum, leading to a certificate; a Community Psychiatry Forum; all-day workshops; and consultations. In addition to fulfilling specific needs, the program has created a professional "community" of the many groups involved in psychiatric teaching, practice, and research.

THE ASSOCIATED FACULTIES Program in Community Psychiatry (AFPCP) was organized in 1964 to develop a program of continuing education in community psychiatry for the Washington, D.C., metropolitan area. The program is guided by representatives of the 15 major psychiatric teaching institutions in the area. They include the three medical schools and civilian and military psychiatric centers in Washington and nearby Maryland and Virginia. They are as diverse in nature as the Washington Psychoanalytic Institute, the U.S. Naval Hospital in Bethesda, Md., and the Fairfax-Falls Church Mental Health Center in Virginia but have in

common the responsibility for conducting training programs in psychiatry.

The consortium set as its first tasks the building of a teaching program including a two-year series of seminars and a practicum, leading to a certificate, and the development of a study group of representatives of the participating institutions. The latter, called the Community Psychiatry Forum, would supervise the teaching program and discuss issues and program developments in community psychiatry. As far as we know, this is the first instance in which all of the psychiatric teaching institutions in a metropolitan area have joined together to sponsor a teaching program in psychiatry.

Administrative direction is provided by three psychiatrists who work part-time for the AFPCP. One, the chairman, provides overall direction and coordinates programs for the monthly forum meetings. The other two have primary responsibility for the curriculum of the teaching program—one coordinating the seminars and the other the practicum. All take part in newer developments of the program, including workshops and consultations. Support has been provided by a training grant from the National Institute of Mental Health and by tuition fees.

After seven years of operation, the impression is that this experiment in interinstitutional collaboration in postgraduate professional education has been a successful one. The consortium is still alive and is growing, which may well constitute a record of sorts for such endeavors. Member institutions remain involved and active, and there is growing evidence that they view the AFPCP as neutral turf where certain sensitive issues may be explored and resolved. More than 400 psychiatrists and other mental health professionals have been involved with the program in one capacity or another during the seven years of its existence.

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The Teaching Program

In the fall of 1965 a class of 23 psychiatrists entered the teaching program. This group represented a wide range of experience and institutional affiliations. Since then four additional classes have completed the two-year course of study. A total of 82 psychiatrists and 13 other mental health professionals have enrolled, and 45 have graduated. The current class has 14 trainees.

In the first four classes, only psychiatrists were accepted into the program. The rationale was to permit the staff and faculty, together with the trainees, to clarify the function of the community psychiatrist as much as possible. Beginning with the fifth class, other mental health professionals have been accepted for the purpose of reflecting the interdisciplinary nature of community mental health in our training. For the next phase of the program, we intend to strengthen the participation of nonpsychiatrist mental health professionals.

We will briefly describe the current structure of the teaching program and then review the process by which it evolved. Meetings are held one evening a week for two hours. The format is that of a small group seminar, with discussions focusing on literature, case histories, and experiences of the participants.

The course of study emphasizes three principal elements: 1) a discussion of the literature of social and community psychiatry, 2) a study of the community and the ways in which psychiatrists and other mental health workers function in communities, and 3) a practicum enabling the student to gain supervised field experience in some aspect of community psychiatry.

The first year includes such units as Introduction to Social Psychiatry, Mental Health Consultation, the Nature of Black History, and a Practicum. The relevant parameters in social psychiatry are covered, with the material divided into three sections: crowd and group phenomena, social determinants of the individual's behavior, and the behavior laboratory. Reading assignments cover psycholinguistics, significant researches of early American sociologists, the brutal laboratories of war and poverty, the theater of the absurd, and modern psychiatric iconoclasts.

Theories and methods of mental health consultation are presented later in the first

year. These discussions are correlated with the practicum. Each trainee is required to develop a specific community mental health project in collaboration with his home institution; it is hoped that the project will constitute a contribution to his institution's work in the community. After approval of the project by the home institution, supervision is arranged by its representative in collaboration with the AFPCP staff. This arrangement for supervision of the practicum is a recent modification and has provided a significant stimulus to the involvement of several institutions in consortium activities.

The unit titled the Nature of Black History not only deals with working in the inner city but also focuses on more general issues: the nature of black-white relations considered as a process, caste and class models of behavior, development of clandestine cultures, and the role of the outsider as a helping person.

Since awareness of group process is regarded as a crucial element in the training of a mental health administrator, experience in a group relations conference is recommended before the second year. This requirement, new this year, is an outgrowth of our awareness of a recurring problem in the seminars.

The subject units in the second year include Mental Health Administration, Advanced Consultation, Advanced Social Psychiatry, and Practicum. Mental health administration is taught by the case method. A series of cases has been developed, highlighting issues and problems in administration. Consultation is studied critically in relation to the various settings in which it occurs and the diverse ways in which it is practiced, with particular attention to illustrative issues in the students' own practicum activities.

By the second year, the practicum has developed to the point where the group can serve as its own faculty, presenting at monthly intervals its own varied experience and sharing the problems and successes of the various endeavors. Before graduation the trainee is required to submit a paper describing his practicum experience.

We continue to refine the teaching program to meet the students' changing needs and interests in response to suggestions from graduates and from member institutions. For example, the series of seminars on the nature of black history was introduced this past year. It offered an immediately practical ap-

plication of the social and cultural understandings acquired elsewhere in the program and stirred up more interest and discussion about current social problems than any other feature of the course.

Another recent change, beginning the practicum early in the first year, has been quite successful. Where consultation relationships need to be established, ample time is now available for planning, setting up, carrying out, and at times terminating the project. The practicums of the 1969-1971 class covered a variety of activities in community mental health practice; a partial listing of titles will illustrate the scope of interests and activities: Psychiatry, and the Communications Media; Consultation with a Radio Station, Mental Health Consultants in an Educational Charrette, Development of the Inpatient Service in a Community Mental Health Center, Bringing Community Mental Health Learning to Clergy, Consultation to Urban Family-Style Communes Serving Juvenile Runaways, Implementation of a Therapeutic Community at a Chronic Disease Hospital, and the Community Mental Health Center and the General Practitioner.

Several issues have emerged in our continuing effort to improve the curriculum. These are briefly summarized as follows:

The chicken-egg problem. Since the inception of the program, the question has been: Which should be taught first, theory or practice—the literature or the work? Originally it was theory first, then practice. Over the past three years there has been an increasing mixing of the two, so that the present curriculum weaves in and out between the theoretical and practical, depending on the special needs of each class.

Allocation of priorities. In a part-time program the difficult problem is what *not* to teach. What should be left out? Emphasis is placed on subjects not taught elsewhere in the Washington area and cognizance is given to the needs and backgrounds of each student group.

The process-content problem. In each class difficulty has been experienced as to whether to emphasize group process or course content. This has been worked out by a compromise, after varying degrees of conflict. The new curriculum requires that students have participated in a group relations conference sometime before the end of the first

year of training. This not only provides a significant experience in group process but serves as a laboratory in administrative issues, material that will be utilized in the more formal consideration of administration in the second year. In addition, we hope that the learning opportunity can be maximized, with less time devoted to group process problems in the class.

The who-is-the-expert problem. Many students have had as much experience in the field of community psychiatry as the faculty. To deal with what is often an artificial distinction between student and teacher we have worked into the curriculum as many opportunities as possible for participants to teach one another. This is most apparent in the practicum sessions, but it permeates the entire program.

Member institutions' needs. While the more obvious goal is to teach community mental health to individuals, a parallel aim is to provide a continuing educational service to member institutions. Pooling efforts and resources makes possible a program that no single institution could carry out alone.

Caste-class problems. After much theoretical discussion about the problems of the middle-class psychiatrist working in a lower-class, often black neighborhood, we decided to offer several sessions on the nature of black history. As noted earlier, the initial attempt this past year proved extremely valuable.

The interdisciplinary problem. Psychologists, social workers, and other mental health professionals were invited to become members of the class that started in 1969. Six enrolled and four completed the course—two social workers, a psychologist, and a mental health center chaplain. The introduction of nonpsychiatrists into the program has had the effect of forcing each participant to sharpen his awareness of the contribution that his discipline can make in service to the community. Although community mental health is an interdisciplinary endeavor, problems often arise because of the difficulty professionals in different fields have in identifying their special contributions. As a consequence, the interdisciplinary approach often deteriorates into one large, undifferentiated personnel mass. Concepts of responsibility, salary and staff structure, and community credibility suffer. In the laboratory of the class we attempt to hammer out these issues, aided by

the fact that the faculty also represents several disciplines.

The teaching program has undergone a continuing evolutionary change. In the intensified examination of the curriculum during the past two years, many problems and issues were considered, solutions were sought, and changes were weighed and adopted. What has emerged is a program with the following significant characteristics:

1. *It is a part-time program.* The goal has been to offer continuing education to those in full-time jobs.

2. *It is an integrated program.* The staff participates in all parts of the program, assuring continuity of faculty and content. In addition, key topics are not isolated in a discrete course but are discussed in the seminars from time to time during the two years, depending upon program relevance and student needs.

3. *It provides a service to both students and member institutions.* The practicum is expected to result in a contribution to the student's home institution's service to the community.

4. *It is balanced between theory and practice.* Assignments are made to stress the applicability of theory to practice and vice versa.

5. *It teaches administration in two distinct ways.* Study by the casework method and participation in a group relations conference provide complementary approaches to administration.

6. *It approaches inner-city problems.* The course on the nature of black history relates course material to the students' professional experiences.

7. *It is interdisciplinary.* Because community mental health is a team endeavor, the program is offered to all professional mental health workers in an effort to foster teamwork and to clarify the role of each team member.

8. *It provides opportunities for continuing participation by graduates.* After completing the teaching program, graduates are encouraged to participate in the monthly forum meetings and the workshops.

The Community Psychiatry Forum

The monthly luncheon meetings of the

Community Psychiatry Forum have become popular and valuable get-togethers for community psychiatry educators, administrators, and clinicians. Participants include representatives of the consortium members, the AFPCP faculty and staff, and varying numbers of invited guests. There are usually 30 or more persons in attendance.

The focus of these discussions is on presentations by members and guests of issues or programs in community psychiatry. For several years each meeting was devoted to a different subject, selected because of its timeliness or general interest. For example, when the Poor Peoples Campaign of 1968 brought several thousand people into Washington for a period of weeks, a forum meeting was devoted to a discussion of psychiatric services provided to those living in the camp-city.

Recently we have set a theme for each year and explored it more exhaustively from several viewpoints. In 1969-1970, for example, the theme was Violence, and discussions were held on such topics as A Study of Violence, Is the City Dying? The Role of Drugs, and Theories and Strategies for the Control of Violence.

Last year's theme was Social Unrest. Eight meetings were devoted to it, including the topics Student Unrest, Youth Behavior, Value System of White Working-Class Youths, and Student Values from a Black Perspective.

This year we are studying the relationship of an academic medical center to an inner-city community by means of a jointly sponsored drug abuse program. It is an attempt to explore the political, institutional, and community issues involved in delivering services, with emphasis on problems and their solutions.

It is apparent that topics discussed at forum meetings are applicable to many real-life situations in the community. This offers all participants the opportunity to talk to others with similar interests about the implications of these issues for training mental health personnel and for providing services.

To provide an additional forum for member institutions and other mental health agencies in the metropolitan area, we have developed a series of all-day workshops on community mental health themes. The participants are chosen to represent a wide diversity of professional and nonprofessional

mental health workers, many of whom would not ordinarily attend the forum or enroll in the teaching program. By reaching them through the workshops we hope to increase our effectiveness in providing continuing education to many persons responsible for training in mental health or the delivery of services.

Some of the topics that have been taken up in workshops are: Community Psychiatry in Residency Training, New Careerists in Mental Health, Mental Health Nursing, and Administration in Community Mental Health Centers.

Beginning in 1971 the staff of the AFPCP has arranged monthly meetings with the Director of the District of Columbia Mental Health Administration and the directors of the four community mental health centers in the city. These meetings concentrate on work-related issues in the centers, striving for clarification of the issues, definition of problems, and exploration of solutions. The role of the AFPCP staff is essentially that of consultant.

Each session centers around an informal statement by one center director of problems he is likely to have in common with the others. The benefits of such a discussion in a setting free of the necessity for making administrative decisions are apparent.

The staff has also offered consultative services to other groups in less formalized arrangements over the years.

Conclusions

We have described the Associated Faculties Program by outlining its component

parts, particularly its major educational effort, the teaching program. To leave it at that, however, would omit an important element of the program, for the whole is considerably greater than the sum of its parts.

The program's existence has promoted interinstitutional cooperative efforts that otherwise would not have been possible. It has opened up channels of communication that are badly needed—but often do not exist—among educational and service institutions in a large metropolitan area. It has provided a forum where anyone and everyone interested in community psychiatry can meet and talk about problems and programs of common interest. It would be no exaggeration to say that this consortium has created a professional "community" of the many groups and organizations involved in community psychiatric teaching, research, and practice.

Member institutions have both contributed to and benefited from the program. They have provided leadership in promoting community mental health concepts in their own training programs and in the community at large. The teaching program's graduates are applying their skills in many programs of training and service in area institutions.

Finally, as an educational experiment, the AFPCP has demonstrated that a part-time faculty and staff can conduct a valuable part-time teaching program in community psychiatry. Although no one in the program has his primary professional identification with the consortium, this has not prevented each participant from contributing his expertise to its effective functioning. The result has been a truly collaborative effort in continuing education.

This Month's Special Section

Group Therapy

Peer Confrontation Groups: What, Why, and Whether

BY WILLIAM W. VAN STONE, M.D., AND ROBERT GILBERT, M.S.W.

The authors describe a program using the principles and methods of peer confrontation groups—treatment settings for addicts, alcoholics, ex-convicts, etc., in which nontraditional control by the participants is used to try to bring about radical changes in the values and life-style of the members. Their program appears to counteract and contain the severe authority conflicts, dependency, underlying hostility, and profound narcissism associated with certain patients who have character disorders. A preliminary follow-up indicated that about half of those who entered the program had benefited significantly.

MENTAL HEALTH PROFESSIONALS have been frustrated and discouraged in their attempts to treat patients who are addicted to alcohol or drugs, or who exhibit similar forms of self-destructive or sociopathic behavior(1). Lay groups have attempted to fill the gap with self-help organizations such as Alcoholics Anonymous, Synanon, and Seventh Step (2), with varying yet promising success. There have been recent attempts to develop new approaches to these problems that combine the assets of established mental health professionals with the empathy and practical

know-how of those who have "been there" (3, 4).

For three years the Palo Alto Veterans Administration Hospital has sponsored a peer confrontation group program stimulated by Synanon (5), a "character disorder ward" (Project 49) at Oak Knoll Naval Hospital (6), and the drug and alcohol addiction units at Mendocino State Hospital in California (7, 8). This paper will describe characteristics of the program and some results to date, attempt to enumerate ways in which it and similar programs differ from traditional approaches, and explore these differences to see how they may throw new light on the challenging problem of motivating and treating these difficult patients.

Program Description

Our program is housed in an open psychiatric ward with an average of about 40 inpatients who are seeking help with alcoholism, drug dependence, gambling, sexual deviation, repeated conflicts with the law, or other self-defeating life-styles. All enter the program voluntarily but some of them come as a partial condition of probation or parole. Labeling the members with the symptoms that brought them in (i.e., alcoholic, addict) is actively discouraged in order to break that pathological association. Until mid-1970, 72 percent of our patients had primary problems with alcohol, but lately the number of drug abusers and addicts has increased. The ages ranged from 20 to 60 with the median in the early 40s.

Read at the 124th annual meeting of the American Psychiatric Association, Washington, D.C., May 3-7, 1971.

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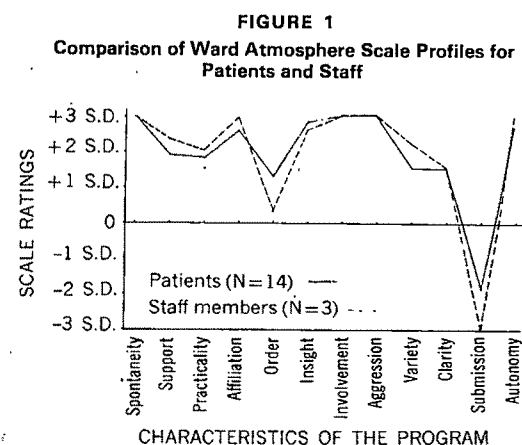
The essential parts of the program are controlled by the members, many of whom are suspicious of and particularly sensitive to the subtle derogatory attitudes seen in many institutions (9). The program has been staffed by a combination of professionals and non-professionals (10, 11), some salaried and some still on patient status. All participants in the program are considered members whether they are on the staff or not. At the present time there are only three paid staff members in the program. Two are counselors, one a former nursing aide and the other an ex-addict recruited from the program, and the third is the director, a charismatic social worker with 19 years of experience in prison and parole work and in the treatment of alcoholism. Medical and nursing coverage and clerical help are provided when needed from other areas of the hospital.

Treatment Method

Motivation of the participants to change, a classic problem (12), is encouraged by the following combination of structural and philosophical characteristics:

1. *An individualized negotiated treatment contract between each potential member and his peers.* An applicant must have stopped taking all drugs, alcohol, or tranquilizers for a sufficient period to have a "clear head" before he will be seen by an intake group composed of program members. The intake process is an intensive interview of the candidate by his peers, who at one and the same time test his motivation by stripping him of his characteristic denials and rationalizations and encourage his motivation by what they can uniquely offer him—a chance to change his ways as they have demonstrably done. Some applicants must return more than once before they are admitted, and approximately one-half are rejected as unwilling to commit themselves to attempt what amounts to a radical change in their life-style. The contract is very individual but generally includes the obligation to have all relationships in and out of the program scrutinized by the group and the right to question anyone or anything at any time.

2. *A 24-hour-a-day live-in setting, away from the previous social milieu of the participants.* Involvement of at least six months is



recommended,¹ but the goal is to return the member to the community as early as possible. During the first few weeks, members are stringently controlled regarding contacts outside the ward. Families, however, are included in the treatment process whenever possible.

3. *A drug-and-medication-free environment strongly oriented toward personal growth and learning.* The emphasis is on "people instead of pills." Emotional openness, honesty, and a sense of humor are encouraged, as well as the development of a capacity for close relationships. Patients, staff, and the many visitors who have become involved in our program have enthusiastically described a feeling of belonging to a very special, close-knit "family." The members are clearly concerned about each other, yet are uncompromising in their demands for conformity to the new group ethic.

4. *A highly authoritarian member-controlled social structure* is constantly evolving from within the membership, with graduated responsibilities, status, and jobs designated for each member. Paid staff members are part of the fabric of this organization and have neither more nor fewer privileges than other members.

This real control by participants and avoidance of a staff-patient dichotomy is an essential ingredient of the program. A Ward Atmosphere Scale developed by Moos and Houts (13), given to more than 300 psychiatric hospital wards in this country and abroad,

¹ Compare the studies of Rosenthal (3) and Yablon-sky (5), who report a much longer period required for drug addicts.

revealed findings for this program that contrasted markedly from those of other wards tested (see figure 1). No significant differences between staff and patients regarding their perception of important aspects of the program were seen; in addition, members on this ward scored three standard deviations (+3 S.D.) above the norm on such characteristics as spontaneity, affiliation, insight, involvement, sanction to express aggressive thoughts, and autonomy.

5. Within this special kind of "therapeutic community" setting there are *group confrontation sessions*,² a kind of group therapy in which each member in turn is presented with candid, personal facts regarding every observable behavior or attitude recognized by the group as being self-defeating or dishonest. If the member under scrutiny attempts to explain away or deny any observation, he is ridiculed, browbeaten, shouted down, and insulted as his fellow members "hammer away at the distorted ideas that he offers in support of his damaging behavior patterns" (16). Intellectual insight or genetic self-interpretations are derided as an escape from responsibility for current behavior. Honesty, trust in the group, realistic self-assessment, appropriate emotional release, and changed behavior, in particular, are rewarded by sympathetic counsel and encouragement from fellow members.

In contrast to the situation in traditional group therapies, the development of classical transference between "patient" and "therapist" is studiously discouraged by rearranging the composition of group membership at each meeting, rotating more experienced leaders, and by ensuring that each leader takes his turn as "patient" (is confronted) at every group session. Senior members emphasize positive role-modeling (the "real relationship") (17) rather than taking a nondirective approach. Systematic reassignment of members to different groups also protects the program against special cliques and against untherapeutic alliances between two or more members. Wilson described the sessions thus:

² Like the small "s" synanon (5), "the game" (14), "attack (confrontation) therapy" (10), or Rosenthal and Biase's "encounter" (3), this form of intervention differs in each setting and is inextricably related to the particular social milieu. Note also that Rosenthal and Biase's "encounter" differs markedly from "encounter groups" as described by Burton (15).

When a patient . . . has abreacted enough suppressed rage and clasped hands with the others, he has reached a level where he has a powerful impact on newer members. For he is one of them—*a* so of the psychologically impoverished culture. He too is a "nut and a loser" with one exception, he has unmistakably a growing ego, he looks and acts more healthy. At this point he finds that he can meaningfully "give back" to others. For he can now not only see personality flaws in others, he can also help his brothers out of behavioral pathology (14).

Evaluation of the Program

After three years the program itself is healthy—still constantly changing, adapting, and growing, while at the same time retaining its basic characteristics. Rather than a disrupting influence on the hospital, it has been a constant source of stimulation and has created favorable national attention. Yet the goal of such a program and the justification for continuing it should not be merely its survival but returning its members to society better able to cope than before they entered.

We have been unable to design an appropriate randomly constituted control group, and the nearest comparable population reported in the literature primarily describes alcoholics (18). For descriptive purposes, therefore, we developed a partially objective rating system based on the ex-patient's ability to hold a job, to find a satisfactory living arrangement, and to avoid the symptomatic behavior that first brought him to us. Ratings were given on discharge and were updated unsystematically from information gained during drop-in visits, reports from friends, correspondence, VA records, and telephone calls, and from a detailed questionnaire mailed out annually. We plan to follow as many graduates as possible for up to three years and will describe our results in a subsequent paper, but we can report our preliminary findings here.

Results

During the first 27 months, 263 men entered the program. In September 1970, when the program was most recently evaluated, 40 of these men were still inpatients and were excluded from follow-up evaluation. Of the 223 who have left, 106 (48 percent) were rated "considerably to greatly improved," and 117

TABLE 1
Rating of Improvement According to Length of Time in Program

CATEGORY	LESS THAN TWO WEEKS	14-30 DAYS	31-60 DAYS	61-90 DAYS	91- 120 DAYS	121- 150 DAYS	151- 180 DAYS	181- 210 DAYS	211- 240 DAYS	241- 270 DAYS	271- 300 DAYS	MORE THAN 300 DAYS
Total attendance	49	24	32	44	21	16	16	8	5	3	1	4
Ratings												
Greatly improved	0	1	3	13	5	5	7	6	2	2	1	3
Considerably improved	2	5	10	17	10	7	5	1	1	0	0	0
Limited improvement	10	11	17	12	6	4	4	1	1	1	0	0
No significant change	37	7	2	2	0	0	0	0	1	0	0	1

(52 percent) were rated as showing "limited or no improvement." The length of stay ranged up to 14 months. The 49 men who stayed in the program less than two weeks generally did poorly. The median stay of the others was 75 days. Although there was clearly a positive correlation between length of stay and positive ratings (see table 1), there was also considerable overlap, which suggests that individual factors, both psychological and circumstantial, were more important than the number of days in the program per se.

Discussion

It is worthwhile to emphasize that the characteristics of this program and its predecessors have evolved gradually out of the cumulated experience of and feedback from its members. Ideally, what works is retained, what does not work is discarded. It may be, thus, that these programs' unique features may counteract just those problems which have proven so frustrating to professionals using traditional techniques. For instance, we can consider such familiar issues as the authority struggle, strong dependency needs, deep-seated hostility, and the pervasive narcissism that characterizes many of these patients who are so difficult to motivate for treatment using traditional methods (12) and explore how they are handled differently in our nontraditional setting.³

1. *The authority conflict* (that of seeking out, yet resenting, a parental kind of intervention) commonly seen in addictive and antisocial personalities is neatly bypassed in this program by isolating the member from those authority figures he has managed to surround himself with in the community, by insisting

that he take responsibility for designing and enforcing his own contract with the membership, and by replacing traditional hospital authorities with cultural peers whose qualifications for leadership may be challenged at any time.

2. *Excessive dependency* (defined as an excessive need to be cared for) is partially gratified by the provision of an institutional setting where basic needs are provided, by an emphasis on belonging to a strong and powerful group, and by the use of supportive non-verbal techniques (16) employing physical contact, such as hand-holding, hugging, massage, and group "lifts" in which a member is held off the floor by his fellows as they encourage him to "trust" and "relax." These contacts provide a surprising amount of support and are well accepted by group members in spite of the usual taboos in our society against such contacts between (male) adults. On the other hand, strong sanctions against passive-dependent behavior, along with an emphasis on growth, responsibility, and self-direction, are gradually brought to bear as individuals are assigned progressively more responsibility, based on proven achievement in the program.

3. The patients' *persistent hostility*, often masked or denied, is frequently accompanied by depression or built-in self-punishment. This hostility can be exposed and redirected usefully in the group sessions, where verbal anger, directly and accurately focused, is a prime skill to be learned. In addition, the warmth and concern demonstrated by the group leaders can directly counteract feelings of loneliness, rejection, and alienation that characterize many of the members.

4. The *narcissism*, or extreme self-centeredness, seen in many of these people is relatively ego syntonic and presents a formidable resistance to traditional psychotherapy. Here reality distortion, min-

³ Boorstein (19) has presented a thorough discussion of the problem from a psychoanalytic frame of reference.

imized in the perceptual sphere, is profound in the areas of self-appraisal and relations with other persons. It is specifically these aspects of the personality to which the group confrontation sessions address themselves. Denials, rationalizations, and distorted values and relationships are vigorously attacked in the group session by peers who are only too familiar with these patterns.

Critique

There are three characteristics of our program that have created special problems with respect to gaining professional support:

Religious overtones. The program has been criticized as being more a religion or cult than treatment. In the broadest sense this is probably true, as shown by the leaders' somewhat dogmatic insistence on the power of faith (trust), hope, and love, and a tendency to view their method as the one "true" path to maturity, even when compared with similar programs. In addition, the total life commitment to the program demanded by the members clearly poses a barrier to scientific description, didactic teaching, and recruitment. These characteristics, however, are shared by other psychotherapeutic endeavors.

Nonprofessional control. There has been speculation that the nonprofessional control we encourage is dangerous and, in fact, represents professional irresponsibility. In this program, within its institutional setting, we have seen no evidence to support this to date. In fact, we feel that in order to create the responsible social system that has been described, one *must* allow real control by the program members. This includes, however, their responsibility to make the program survive within the institution and the greater community and their responsibility for self-policing. In marked contrast to most institutional programs dealing with alcoholism and drug abuse, ours has remained clean of alcohol, drugs, or disturbing behavior for the three years it has existed.

Confrontation. Some outsiders have expressed alarm at the vigorous and frequently obscene direct attack on character defenses that is encouraged in confrontation sessions, particularly when done by "amateurs" who may gain personal satisfaction from the confronting (20). This alarm is quite understandable. We have found, however, that the

intake screening, the voluntary nature of the program, the constant monitoring of behavior, and easy access to skilled professionals effectively provide escape routes for those who cannot tolerate the intensity of the sessions. We have had no casualties from patients who did not have a history of a previous psychotic breakdown. Among the 15 who did have such a history, two became overtly psychotic again while in the program, four others left without signs of any change, six appeared to be improved but are still struggling with their illness, and the remaining three appear to be well adjusted and completely asymptomatic. Professionals must not underestimate the importance of the constant, concerned support provided by the entire membership before, during, and after the confrontation sessions. To have such sessions alone, without the supports and safeguards of the social milieu described above, is most likely not justified and possibly dangerous.

Summary and Conclusions

Peer confrontation groups, as described in this paper, refer to resocialization settings for addicts, alcoholics, ex-convicts, and others, where nontraditional methods controlled by the participants are used to attempt radical changes in the values and life-style of the members. The Palo Alto VA Hospital has sponsored such a program since March 1968. The vital characteristics of our program appear to be: an individualized negotiated treatment contract between each potential member and his peers; a 24-hour-a-day live-in setting away from the previous social milieu of the participants; a supportive drug- and medication-free environment oriented toward personal growth and learning; a highly authoritarian, member-controlled social structure constantly evolving from within the membership; and periodic group confrontation sessions with strict rules, including energetic verbal confrontation of each member regarding self-destructive behavior, admixed with the warmth and empathy of a "suzer-family." These five characteristics, working together, appear specifically to counteract and contain the severe authority conflicts, dependency, underlying hostility, and profound narcissism associated with certain patients classified as having character disorders. Preliminary follow-up of over 200 grad-

uates of the program, using a broad range of partially objective measures, reveals that approximately one-half of those who entered the program were significantly benefited. The lack of an appropriate control group, or of descriptions in the literature of comparable groups, makes conclusions premature. However, as clinicians we cannot help but feel optimistic regarding a type of program that appears to help patients whom most professionals avoid. We feel that increased attention, study, and support of this and similar programs is warranted in order to learn how they may fit into the broader rehabilitation picture. More importantly, their methods may offer a basis for renewed hope not only for those with addictive problems but for the urban poor, school dropouts, delinquents, and similar "unmotivated" groups where traditional professionally designed and controlled methods have proven outstandingly ineffective (21).

REFERENCES

1. Patch VD: Human behavior, medicine and social reform. *New Eng J Med* 280:1415-1416, 1969
2. Sands B: *The Seventh Step*. New York, New American Library, 1967
3. Rosenthal MS, Biase DV: Phoenix House: therapeutic communities for drug addicts. *Hosp Community Psychiat* 20:26-30, 1969
4. Shelly JA, Bassin A: Daytop Lodge: a new treatment approach for drug addicts. *Corrective Psychiatry* 11:186-195, 1965
5. Yablonsky L: *Synanon: The Tunnel Back*. New York, Macmillan, 1965
6. Holm VM, Edwards D, Gunderson EKE: Project 49: an evaluation of a therapeutic community. *Milit Med* (in press)
7. Wilson WM: Hospitalized drug addicts aid public education. *Hosp Community Psychiat* 19:379, 1968
8. Wilson WM, Helm S: An alcoholism program tailored to community needs. *Hosp Community Psychiat* 21:406-408, 1968
9. Mogar RE, Helm ST, Snedeker MR, et al: Staff attitudes toward the alcoholic patient. *Arch Gen Psychiat* 21:445-454, 1969
10. Kadushin L, Kadushin A: The ex-addict as a member of the therapeutic team. *Community Mental Health Journal* 5:386-393, 1969
11. Sobey F: *The Nonprofessional Revolution in Mental Health*. New York, Columbia University Press, 1970
12. Canter FM: A self-help project with hospitalized alcoholics. *Int J Group Psychother* 19:16-27, 1969
13. Moos RH, Houts PS: Assessment of the social atmospheres of psychiatric wards. *J Abnorm Psychol* 73:595-604, 1968
14. Wilson GC Jr: Preliminary report on Project 49, Oakland Naval Hospital, for treatment and rehabilitation of character disorders in a voluntary, self-help, open ward setting. Oakland, Calif, Oakland Naval Hospital, 1968 (processed)
15. Burton AE: *Encounter*. San Francisco, Jossey-Bass, 1970, pp 15, 198
16. Balgooyen TJ: Personal communication to Gottlieb A, Dec 12, 1968
17. Greenson RR: *The Technique and Practice of Psychoanalysis*. New York, International Universities Press, 1967, p 216
18. Roban WP: A follow-up study of hospitalized problem drinkers. *Dis Nerv Syst* 31:259-265, 1970
19. Boorstein S: A psychoanalytic overview of the offender: implications for therapy. *Psychoanalytic Forum* 2:245-256, 1967
20. *Encounter Groups and Psychiatry*, Task Force Report No 1. Washington, DC, American Psychiatric Association, 1970, pp 12-17
21. Moynihan DP: *Maximum Feasible Misunderstanding*. New York, Free Press, 1969

DISCUSSION

JEROME STEINER, M.D. (New York, N.Y.)—In the part of their paper labeled "Discussion" the authors point out that authority conflict, excessive dependency, persistent hostility, and narcissism are the factors that make the treatment of their patients by "traditional" methods so difficult. These terms are well defined in that section of the paper, but the discussion is not really integrated with the rest of their presentation.

The patient population studied is not composed of those with character disorders in general but a subgroup—the antisocial character, particularly alcoholics and drug addicts. The patients are further selected so that the sample includes those addicts (primarily alcoholics) who are able to involve themselves in the group experience and be subject to group norms, who have the ego strength to maintain their abstinence for a period of time (unspecified) before entering the program, who also have the ego strength to tolerate the display of hostility in these groups, who are motivated to give up their addiction, and who trust authority enough to submit to planning that often differs from the type of planning that they would ordinarily choose.

In order to participate in such a group, the patient must have a readiness for social interaction, a knowledge of the forms that are entailed in these relationships, and a preexisting model of the family. If one wished to test the premise that some of these patients were learning how to participate in a family and to adopt familial roles for the first time, the study would have to include more non-volunteer members and persons who have had a lifelong pattern of social isolation in order to correct somewhat for this particular selection factor. Were this accomplished, of course, there would be great difficulty in testing the hypothesis about relation to authority. One might speculate that, without a preexisting family model, the patient might learn to relate to other people, perhaps in a

one-to-one relationship, following a pattern of more primitive oral dependency wherein a person, the "feeder," is substituted for the pill. One might wonder whether the patient would adopt the pattern of overindulgence in the person and then attempt to break this habit when closeness became too great, leading to a repeated cycle of overindulgence and flight.

The authors state that the development of transference was discouraged, but one might question whether transference phenomena can be discouraged at all. It is true that a group membership of 15 or so would limit the intensity of familial phenomena, since it would permit better distancing and hence less arousal of the anxiety generated by closeness that is a great problem for the type of patient described. On the other hand, it could create a problem if the total group membership was so large that there was a constantly shifting group membership, as was implied, or if the patient was in the similar position of finding himself in a group only some of whose members were ever there at one time. Furthermore, the rotation of leadership is a fiction based on formal role playing. It is doubtful that actual leadership can be rotated by "assignment." There is a large body of literature in social psychology that discusses this problem. In addition, there is a type of patient whose transference may not be tied to a particular

person but is rather applied to "any part in a storm." There is, for example, the relatively new social phenomenon of people who rotate from one encounter group to another as they read about them in the newspapers.

If these patients are indeed changing because they are receiving a new pattern of gratification and understanding through participation in the family setting, a controlled study should include the results (measured along the same parameters) for a group whose members would continue together beyond the particular inpatient treatment. I doubt that new values and characterological traits could be incorporated during this second time of participating in a family. A more plausible explanation for the behavioral change in the members of these groups is: 1) contingent fear of the ever-present punishment meted out by the group leadership, 2) gratification of the dependency needs that give rise to addiction, and 3) continual expression of the hostility that had been directed elsewhere in society before becoming a member of this group.

There is no doubt that this is an excellent form of treatment for the type of patient described here and that it has a greater chance for success than the more "traditional" modes, but I question whether the "traditional" modes are used any longer.

The Psychodynamics of Quitting Smoking in a Group

BY JOHN S. TAMERIN, M.D.

The psychodynamics of quitting smoking were identified from observations of small groups established to study the cessation process. Three major issues emerged: 1) the expectation of failure, 2) the feared loss of control, and 3) the affective significance of the loss. Belief in success was a necessary precursor to actual success. A feared loss of control was common but seldom materialized to the degree anticipated. The dynamics of grief with associated tearfulness were central to the process of quitting.

resulted in a massive public health campaign aimed at communicating the hazards of smoking to the general public (2). As a result, 90 percent of the adult population now recognizes the dangers of smoking (3). However, despite an intellectual awareness of risk and a desire to quit, millions of smokers are unable to stop smoking. The same survey (3) found that 22 million adults who are currently smoking cigarettes made at least one serious but unsuccessful attempt to quit during the four years between 1966 and 1970.

In view of the seriousness of smoking as a

IT HAS BEEN estimated that over 300,000 excess deaths occur every year in the United States as a result of cigarette smoking (1). The seriousness of this problem has

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health problem and the apparently involuntary aspects of this behavior for many smokers (4), it is striking that there has been so little psychiatric interest in smoking. Specifically, the psychodynamics associated with smoking and the cessation of smoking have received virtually no attention in the scientific literature. The purpose of this study is to examine the psychodynamics of quitting smoking as they emerge in groups specifically established to explore and study the cessation process.

Method

The study was conducted at the Silver Hill Foundation, a private psychiatric hospital, with three small groups of smokers from the community who volunteered to participate in a research program designed to help them quit smoking. The groups met five mornings a week for two weeks; the meetings lasted for an hour and a half.

The subjects (N = 16) were primarily college-educated middle-aged women (mean age = 45 years), and with one exception were housewives. All were heavy smokers (mean = 33 cigarettes per day) of many years duration (mean greater than 20 years). Each subject had made at least one serious and unsuccessful attempt to quit on her own. None of the subjects reported overt psychiatric symptomatology before the initiation of the study. None were in psychiatric treatment or contemplated the need for it.

At the initial meeting the subjects completed an intake questionnaire and the tests in the Smoker's Self-Testing Kit (5). They were then instructed to halve their cigarette consumption on each successive day, stopping entirely by the fourth day of the study. The meetings were led by a dynamically oriented research psychiatrist and focused on issues central to the process of giving up smoking. A follow-up interview was conducted with each subject three months after the program ended. In addition to the 16 subjects reported here, nine other smokers attended one or more meetings but did not complete the two-week program.

Results

Three major findings emerged as central to the problem of quitting: 1) the expectation of

failure, 2) the feared loss of control, and 3) the affective significance of the loss of cigarettes.

The Expectation of Failure

The expectation of failure was evident in each subject. This feeling was clearly expressed by one woman at an initial meeting: "I don't really believe I can stop. I've failed so many times before." On the tests in the Smoker's Self-Testing Kit, these subjects scored extremely low (mean = 3.7 with a scale range of 3 to 12) on the factor measuring "capability for stopping." Conversely, the subjects scored very high on factors measuring "psychological addiction to cigarettes" (mean = 13) and "use of cigarettes to reduce negative affect" (mean = 12.8), on a scale with a range of 3 to 15. This constellation of scores reflected the anticipation of extreme difficulty in quitting and general feelings of inadequacy to achieve the desired goal. The expectation of failure was particularly painful for these subjects, who clearly recognized and accepted the health benefits of quitting. Five of the 16 subjects had either emphysema or coronary artery disease, and on a factor measuring "value of stopping," the total group mean was 10.6 on a scale of 3 to 12.

Fears of failure led many subjects to conceal their attendance in the program from their families, particularly from their husbands. Many perceived their husbands as being highly critical of their inability to stop smoking. In some instances this had already led to patterns of "closet smoking," with regressions to adolescent practices of surreptitious smoking in such places as the bathroom, garage, or basement. Low self-esteem was generally evident. Repeatedly, the feeling was expressed by subjects that they were missing some quality that others possessed: "I know I should. I want to quit, but I just don't have what it takes."

The Feared Loss of Control

The fear of losing control in areas as diverse as cognition and motor function, affect, and overall personality organization was frequently expressed. In cognitive and motor spheres, these subjects expressed fears of being unable to concentrate, organize thoughts, remember, drive a car, focus on housework, or even write a letter—all of which, in the past, had been intimately associated with smoking.

The fear of losing control of affect was particularly striking. Repeatedly, subjects expressed anxiety about the possible emergence of uncontrolled hostility. It became evident that cigarette smoking had been used by many as a prosthetic technique—to keep the lid on—and the fear of what might happen if they were to quit was clearly revealed in such remarks as: "People say I'm very patient and that I never get angry. It's because I have these tranquilizers in my pocket. They keep my anger so suppressed that it doesn't come out at all. I think I've used smoking like a blasting mat—you know, the thing they put over a place where they are dynamiting, which keeps the rocks from flying off in all directions and hurting people." A corollary of this fear of expressing hostility was the general preference among these subjects to adopt a masochistic solution to their anger within the family setting. One subject remarked, "Getting angry hurts others. When I smoke I feel a release in my whole body from anger and tension, and the cigarette won't hurt anyone but me."

Much of the concern about losing control of their anger focused on the role of these women as stabilizers within their suburban families—often a role that they accepted with more than a little ambivalence. One subject remarked, "Our husbands can explode when they come home, but we can't. We are supposed to absorb the frustrations of everyone else in the family and still maintain the image of superwife and supermother. I don't want to scream and yell at the family and hurt people terribly, so I smoke." Another woman even went so far as to say, "I'm afraid the family will fall to pieces if I stop smoking and lose control."

Some subjects anticipated complete psychic and personal disorganization with the cessation of smoking. One subject, waxing poetic but obviously reflecting the depth of her need, remarked, "Cigarettes are the rudder on my sailboat. They stabilize my life. In the toughest day or the darkest night, cigarettes are always there."

A number of the feared changes did occur with cessation of smoking. Subjects reported lapses in concentration, a problem remembering things, occasional difficulty when driving, and in some instances, a definitely altered threshold to the effects of alcohol, so that amnesic episodes (blackouts) were re-

ported following ingestion of small amounts of alcohol. Regarding anger, many subjects found themselves not only more irritable and more aware of their own rage, but more likely to express anger than when they had been smoking. One remarked, "I've seen a lot more rage in myself since I've given up smoking." Another said, "I really blew it. Last night I threw a hamburger at my husband." A third subject remarked, "I felt furious last night, completely out of control, like I was having a seizure. I've never felt this out of control in my life." Even more graphic and symbolic was another woman's statement: "Yesterday I was so angry I felt as if I'd bite the neighbor's mailbox."

Despite the fact that some loss of control did occur, this generally lasted no more than a few days and was never as serious as the subjects had feared. Furthermore, it was always reassuring when the brief storm blew over. One woman remarked, "I'm relaxed today and really encouraged that I didn't explode or go crazy or any of those things I expected."

The Affective Significance of the Loss of Cigarettes

A transient period of grief with considerable tearfulness appeared as an almost routine clinical accompaniment of the cessation process. One subject said, "I usually love to cook, but I haven't cooked all week. I have almost no control of my tears. I'm crying all the time." Another subject remarked, "I expected that I would feel exhilarated at stopping but I'm not. I'm depressed. I feel sad and I'm sleeping a lot." The depression was so pervasive in each group that, on the day the subjects were to stop smoking, they all looked as if they were attending a funeral.

The dynamics of grief and loss appeared to be central to the entire cessation process. When these subjects finally contemplated a future without cigarettes, the extent of their emotional involvement became evident. One remarked, "Smoking has been a close part of my life for over 30 years. I smoked before I met my husband. It's a dear friend." Another said, "I think my cigarettes are more like a lover than a friend. I see this as a terrible, personal loss." The permanence of the loss was particularly difficult to bear—one subject expressed the feeling of the group when she

said, "The reason I'm so sad is that I know this time it's forever."

Subjects also became increasingly aware of how they had used cigarettes in the past as a companion and defense against experiences of loneliness or rejection. One subject remarked, "I don't see the cigarette as evil. It personifies all the things I need. When someone turns his back on me, we are together. It takes the sting out of a rebuff. I don't want it to disappear." Another said, "I was alone waiting for my daughter. I lit a cigarette, and I felt I wasn't alone anymore."

Discussion

Can one generalize about a large group of cigarette smokers from findings with a sample that is relatively small ($N=16$) and obviously skewed from the point of demographic and socioeconomic variables (i.e., upper-middle-class, well-educated suburban housewives)? A recent study on a larger and more diverse sample of smokers from another cessation program in Philadelphia (6) revealed a strikingly similar profile on the Smoker's Self-Testing Kit. As in this study, there was a high score on the factor measuring "value of stopping," clearly suggesting that the educational aspect of the antismoking campaign had been successful. Moreover, a similar pattern of high scores on "psychological addiction" and on "use of cigarettes to reduce negative affect" in combination with an extremely low score on "capability for stopping" indicates that there are now a growing number of smokers who need psychological rather than educational assistance.

In treating cigarette smokers, the first problem that must be dealt with is their overwhelming expectation of failure. Schwartz and Dubitzky (7) found that feelings of low self-esteem correlated with an inability to stop smoking. A national survey of smokers (8) revealed that the anticipation of failure was associated with a subsequent lack of success in quitting. The initial goal of treatment, therefore, must be to help smokers gain the belief that they are capable of succeeding in this area. In this study, it was repeatedly observed that belief in success was a necessary precursor to actual success.

The first step in this process, particularly in a group setting, is to help smokers who feel guilty about not being able to quit recognize

that they are not unique and that there are others just as addicted, just as frustrated, and just as unsure about their capability for stopping. Second, the mechanism of identification with others going through the same cessation process is essential to recognizing that the process is not as overwhelming as the individual smoker may have anticipated, and that "if they can do it, I can do it, too."

The relevance of peer identification to belief in one's own capability for quitting has important implications for mass media approaches. Since continued smoking may in many instances be related to fears of failure, messages to influence this behavior are more likely to be successful if they come from "average" smokers who were able to quit in spite of extreme anxiety and fears of failure. The present tendency to use movie stars or white-coated physicians as models for identification does nothing more than to annoy and frustrate the helpless and self-deprecating smoker, without in any way enabling him to feel that "if they can do it, I can do it, too."

The groups in this study were so successful in providing support, empathy, encouragement, and the opportunity for shared identifications that by the end of the two-week period, the sample as a whole had reduced their average daily consumption of cigarettes from 33 to 1.5 per day, and 11 of the 16 subjects had stopped smoking entirely. With the termination of the groups considerable backsliding occurred, however, so that by the three-month follow-up the average daily cigarette consumption was up to 14 a day. Although five subjects (31 percent) were still not smoking, an equal percentage had returned to their previous level of cigarette use. The problem of recidivism following group termination would suggest that, just as in the area of alcoholism, long-term support is indicated, and that a voluntary, nonprofit organization modeled in some ways on Alcoholics Anonymous might be useful.

The central role of cigarettes in the defensive structure of the chronic smoker explains the intense fear of loss of control when this act is abruptly terminated. The smoking cessation group can be particularly helpful in this regard by reducing anxiety through shared fantasies of loss of control. In addition, the group enables the individual to relax his or her own rigid controls and permits not only greater affective expression but even lets

temporary loss of control occur.

The significance of smoking as a means of controlling affect and regulating psychic equilibrium has implications not only for smoking cessation groups, but also in the psychotherapy or psychoanalysis of any patient who smokes. In view of the ubiquity of cigarette smoking, the importance of this activity in the life of the smoker, and its compulsive, risk-taking, and addictive aspects (4), it is striking that psychiatrists have paid so little attention to this act. What amounts to almost a selective inattention may be related to the unusually high prevalence of cigarette smoking among psychiatrists (9), or possibly to Freud's own addiction to tobacco (10). More likely, it is related to the fact that, until recently, cigarette smoking has not been perceived as unhealthy to society or ego alien to the individual. Whatever the cause, the tendency to regard cigarette smoking as a relatively unimportant behavior or habit, hardly worthy of the same serious attention and analysis as a neurotic symptom, a sexual perversion, or a compulsive act, deprives the smoker and his therapist of a unique opportunity for the reexamination and working through of unresolved adolescent conflicts.

For many heavy smokers, smoking was instituted in adolescence as a developmental defense against stress; as a means of coping with drives and affects, particularly in conflictual social situations (11); or as an attempt to deal with anxiety arising out of identity conflicts (12). Cigarette smoking may also be initiated during adolescence with a feeling of defiance for authority (13). Cessation of smoking may be helpful in opening up these areas for therapeutic scrutiny. In working with a neurotic individual who has relatively strong and flexible defenses, this may provide an unusual opportunity to uncover conflicts previously obscured and masked by compulsive smoking. On the other hand, in the borderline patient, it is equally important to recognize that precipitous cessation of smoking may be a profoundly disorganizing experience that may throw the individual into frank psychosis (14).

Regarding the concept of loss, it was generally observed that the recognition, acceptance, and working through of the loss was almost a necessary prerequisite to a successful outcome in these groups. One woman

remarked, "I recognized that this was my pal, whether at a party or in a catastrophe. Once I realized that, I felt I could give it up." The working through, however, was invariably a painful process. Subjects generally agreed that they had never before in their lives given up anything as meaningful or with as much pain. The group was particularly helpful in providing a setting where individuals could express their grief and pain without feeling strange or abnormal. In fact, the experience of crying in the group became normal and natural in a setting with others going through the same process. Furthermore, the unique intimacy of these groups of persons with a common goal and facing loss together provided genuine concern and support, which decreased the intensity of each subject's individual suffering.

There is little question that cigarette smoking statistically represents a form of extreme risk-taking behavior (15). It is important to recognize, however, that statistics may be far less meaningful to the chronic smoker (even one with emphysema or coronary artery disease) than the immediate threatened loss of "a dear friend" (the cigarette). For most of the women in this study, and for millions of other smokers, cigarettes represent one of the few consistent and stable objects in their lives. One subject remarked, "My husband travels. My youngest son is now off to college, and I'm home alone. A cigarette is really one of my best friends. I don't know how I could possibly give it up." Anyone who works with the chronic cigarette smoker should be sensitive to these dynamics and must be prepared to deal with the affective consequences of loss that may result from quitting.

In conclusion, certain dynamics that appear to be related to the process of quitting have emerged from a study of 16 women who were chronic heavy smokers in a group cessation program. In order to determine whether these dynamics are meaningful and relevant to the majority of the estimated 9.5 million heavy smokers in America (16) (i.e., adults who smoke at least 30 cigarettes a day), further clinical studies in this area must be conducted.

REFERENCES

1. Diehl HS: Tobacco and Your Health. New York,

- McGraw-Hill, 1969
2. Fletcher CM, Horn D: Smoking and health. *WHO Chron* 24:345-370, 1970
 3. National Clearinghouse for Smoking and Health: A survey of smoking attitudes and behavior. Washington, DC, US Public Health Service, 1970 (processed)
 4. Tamerin JS: Cigarette smoking as a form of neurotic risk-taking behavior. Read at the 5th World Congress of Psychiatry, Mexico City, Mexico, Nov 28-Dec 5, 1971
 5. National Clearinghouse for Smoking and Health: Smoker's Self-Testing Kit, Part 1: The Tests. Public Health Service Publication 1904. Washington, DC, US Government Printing Office (no date given)
 6. Berglund E, McFarland W, Albrecht CE: Field test of the Smoker's Self-Testing Kit: report submitted to the National Clearinghouse for Smoking and Health. Washington, DC, US Public Health Service, 1971 (processed)
 7. Schwartz JL, Dubitzky M: Psychosocial Factors Involved in Cigarette Smoking and Cessation. Berkeley, Calif, Smoking Control Research Project, 1968
 8. National Clearinghouse for Smoking and Health, US Public Health Service: Unpublished data, 1971
 9. Tamerin JS, Eisinger R: Cigarette smoking and the psychiatrist. *Amer J Psychiat* 128:1224-1229, 1972
 10. Wakefield J: Influencing Smoking Behavior, UICC Technical Report Series. Geneva, International Union Against Cancer, 1969
 11. Kissen DM: Psychosocial factors in cigarette smoking motivation. *Medical Officer* 104:365-377, 1960
 12. Brown JAC: The nature and treatment of smoking. *Medical World* 98:187-192, 1963
 13. Stewart L, Livson N: Smoking and rebelliousness: a longitudinal study from childhood to maturity. *J Consult Psychol* 30:225-229, 1966
 14. Tamerin JS, Neumann CP: Casualties of the antismoking campaign. *Compr Psychiat* (in press)
 15. Tamerin JS, Resnik HLP: Risk-taking by individual option: case study—cigarette smoking. *Arch Gen Psychiat* (in press)
 16. Horn D: What's happening to smoking behavior. Read at the National Conference on Smoking and Health, San Diego, Calif, Sept 9-11, 1970

DISCUSSION

MYRON F. WEINER, M.D. (Dallas, Tex.)—"Everybody knows" it's hard to quit smoking. Not many people, before the work of Dr. Tamerin and his associates, have tried to probe the psychodynamics involved and, from that, to form a conceptual model to serve as the basis for a rational treatment approach. The aspect of Dr. Tamerin's paper that intrigued me most was the psychological role of the cigarette as an object relationship, serving various functions, but whose loss is reacted to much as the loss of a loved one.

The differences between reaction to object loss in children and in adults are striking. In childhood and adolescence, loss of a parent is dealt with by denial, blocking of affect related to the parent's death, increased identification with and idealiza-

tion of the dead parent, and persistent unconscious fantasies of an ongoing relationship or reunion with the dead parent (1). Adults react in the manner described by Freud, with gradual and painful emotional detachment from the inner representation of the person who has died (2). Freud's notions have recently been reconfirmed by Clayton and associates (3) in a study of bereavement in adults. Depressed mood, sleep disturbance, and crying were the symptoms experienced by more than half the study group immediately following bereavement. In a follow-up study within three months, 81 percent were improved and only four percent were worse. Those who had improved dated their improvement to six to ten weeks after the death occurred. One woman concluded, "I can't mourn forever" (3).

The quality of the relationship between the addicted smoker and his cigarette, as indicated by the feeling "I can't give it up," expressed by many prior to entry into group treatment, coupled with the real grief felt during treatment, suggests a mixture of childish and adult reactions. The attempt of the therapist to instill hope of success is tantamount to dealing with the regressed, or fixated, aspect of the patient by reassurance that it can tolerate a significant object loss. On the other hand, we know that this aspect of the ego deals with object loss by increased identification and hope of being reunited with the lost object. It need not be demonstrated that smokers who have difficulty "kicking the habit" have suffered object loss in childhood. The point is that they function to a degree, in relation to cigarettes, as a child to a love object.

In the report of a psychoanalytic panel on addiction, it was suggested that the essence of addiction is the substitution of a fantasied object relation for a real one. Self-administration of the addictive substance was seen as a psychological incorporation of the fantasied object that relieves the pain of frustration. In adolescent drug-takers there was a significant history of parental death. The most important therapeutic tools seemed to be a continuing relationship with a helping person who provides supporting ego and superego functions and a group treatment situation involving confrontation and acceptance (4).

What are the implications of these findings for treatment? The mature ego, or adult aspect, of the habituated cigarette smoker requires a reasonable period of time to mourn the loss of an important companion. The fixated or regressed ego, or childish part, requires a substitute relationship. I agree with Dr. Tamerin that group treatment seems a promising approach to the treatment of the habituated smoker, not only because of the inherent group therapeutic factors of universalization and identification but also because group treatment offers the possibility of "real" relations

with other group members during and after the adult grief process has been worked through, which is a more appropriate gratification of the childish wish to be reunited with the lost object.

The study of normal bereavement cited above indicated that a three-month period allows adult grief to be worked through. After the termination of the grief process, time must be allowed for the consolidation of new relationships. How much time is required for this I do not know, but I do know that it is facilitated by the use of alternate sessions, which encourage increased interdependence among group members rather than upon the leader and promote a continuation of relationships among group members that will provide the long-term support that Dr. Tamerin feels is necessary. A reasonable alternative to formal therapy is, as Dr. Tamerin suggests, an organization of lay persons designed to provide mutual ego sup-

port in attempting to promote more rewarding, less life-endangering object relationships than that which obtains between the cigarette addict and his cigarette.

REFERENCES

1. Miller JBM: Children's reactions to the death of a parent: a review of the psychoanalytic literature. *J Amer Psychoanal Ass* 19:697-719, 1971.
2. Freud S: Mourning and melancholia (1917), in *Complete Psychological Works*, standard ed, vol 14. Edited by Jones E. London, Hogarth Press, 1957, pp 237-258.
3. Clayton P, Desmarais L, Winokur G: A study of normal bereavement. *Amer J Psychiat* 25:168-178, 1968.
4. Frosch WA: Psychoanalytic evaluation of addiction and habituation. *J Amer Psychoanal Ass* 18:209-218, 1970.

Group Psychotherapy in the Soviet Union

BY ISIDORE ZIFERSTEIN, M.D.

The decisive influence on the theory and practice of Soviet collective psychotherapy came not from psychiatry but from the field of education. Thus a major aspect of it is education and reeducation—employing the powerful influence of the peer-group collective under the therapist's guidance. The major emphasis is on emotional support, guidance, and reeducation. The author discusses the historical development of collective psychotherapy and the four major contributors to it.

ON TWO RECENT research sojourns in the Soviet Union, in 1970 and 1971, I spent several months making direct observations of Soviet group psychotherapy, familiarizing myself with its history, theory, and develop-

ment. (The Soviet psychiatrists whose work I observed prefer the term "collective psychotherapy," to distinguish their work from the Western type of treatment in groups.)

In tracing the origins and development of collective psychotherapy, I found that four persons stand out as major contributors: S.S. Korsakov (1854-1900), V.M. Bekhterev (1857-1927), A.S. Makarenko (1888-1939), and V.N. Myasishchev (1893—).

Distinctive Characteristics of Collective Psychotherapy

Several significant factors lend to collective psychotherapy its distinctive characteristics:

1. The decisive influence on the essence of collective psychotherapy was exercised *not* by the three psychoneurologists listed above—Korsakov, Bekhterev, and Myasishchev—but by the educator, Anton Semyonovitch Makarenko; i.e., the basic influence on the theory and practice of collective psychotherapy came *not* from psychiatry, but from the field of education. This means that a major aspect of collective psychotherapy is education and reeducation—employing the powerful influence of the peer-group collec-

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tive under the guidance of the therapist, who is the "teacher of life" (1). Both the group and the therapist are the representatives of society and the carriers and transmitters of society's values.

2. Collective psychotherapy developed simultaneously and in conjunction with scientific individual psychotherapy. The origins of both scientific individual and collective psychotherapy are traced by Soviet psychiatrists to Korsakov and Bekhterev, whose lifespans coincided with much of Freud's. In this respect the history of collective psychotherapy contrasts sharply with that of Western group psychotherapy. In the West, Freud and his pupils, the founders of dynamic psychotherapy, did not engage in the practice of group psychotherapy, and for a long time official psychoanalysis stood aloof from group psychotherapy.

Perhaps one reason for this difference is the fact that Freud spent most of his professional life outside the mainstream of medicine and psychiatry. He developed his theory and its applications in his private office. Korsakov and Bekhterev, on the other hand, were always in the mainstream of Russian medicine and psychoneurology. Both were professors in leading medical faculties and directors of leading psychiatric institutes and hospitals. They were therefore keenly aware of the interactions of patients in groups and of the profound influence that their patients exerted on each other in the hospital, in the therapeutic community.

Korsakov's Contribution: "We Cure Each Other"

In the second edition of his *Kurs Psikhiiatrii* [*A Course of Psychiatry*] (published posthumously in 1901), Korsakov wrote: "... The other half [of our therapeutic armamentarium] consists of our patients themselves. The patients, when they are in the hospital, are not only undergoing treatment, but also promote the cause of curing the other patients. Patients sometimes observe this and say: 'We cure each other.' ... And, indeed, many of our patients are the indispensable allies of the doctors" (2).

In this connection, the Russians claim a slight priority over Western psychiatry as originators of group, or collective, psychotherapy (although the former tendency of

the Russians, during the Stalin era, to claim priority in all areas, including the invention of the airplane and the radio, is no longer in evidence). The Russians point out that the second edition of Korsakov's *Kurs Psikhiiatrii*, which preceded by eight years the work of L. Marsh, delineated several basic principles of collective psychotherapy: the use of the collective as a psychotherapeutic influence; the role of the doctor as a unifying factor; the significance of intragroup relationships; the close connection of collective psychotherapy with work therapy and culture therapy; the place of collective psychotherapy in the system of the therapeutic regimen of the hospital; and the unity of collective and individual psychotherapeutic ("moral") influence.

Bekhterev's Experimental Collectives

Bekhterev carried forward and broadened both the theory and practice of collective psychotherapy. In collaboration with M.V. Lange, he attempted to formulate a theoretical basis for collective psychotherapy by carrying out a series of laboratory experiments with groups of students. In this work Bekhterev and Lange demonstrated some of the positive influences of the group on its members. They found that studying in a group increased the area of knowledge of the individual members more effectively than studying individually. They also demonstrated that the influence of the group softened the attitude of individual members toward faults and transgressions in their fellows and enabled members to withstand stronger irritants. Experimental work in groups also brought to light the diverse relationships of each of the members with the collective.

Bekhterev also broadened the application of collective psychotherapy by applying it to groups of patients in an outpatient setting.

Homogeneous Collectives

For a time, group psychotherapy in Russia concentrated on groups of individuals with common presenting symptoms. Thus in 1904 I.V. Vyazemskii treated alcoholics in groups of five or six patients. In 1909 G.D. Netkatchev reported on the collective psy-

chotherapy of groups of stutterers. The groups met daily. To begin with, Netkatchev had the patients bring in a written history of their lives and their illness. On the basis of these life stories, he led a discussion about the specific mechanisms of stuttering, its causes, the role of the emotions, of anxiety, and so forth. He then asked the patients to write out, in their individual journals, their opinions about these discussions. In subsequent sessions the stutterers read these opinions aloud from their journals.

Between group sessions the patients continued to write down their reactions to the sessions as well as their state of mind between sessions. At a more advanced stage of treatment the patients no longer read from their journals but carried on free-flowing discussions.

To this day, there is in the Soviet Union a widespread and effective use of collective psychotherapy for the treatment of stutterers. During my recent stay in Leningrad, I observed a session of psychodrama with adolescent stutterers. The youngsters worked eagerly and imaginatively, improvising scenes from their family and school life. They demonstrated gusto and wit in spoofing parents, teachers, school principals, and government officials. During these scenes of psychodramatic catharsis, the youngsters did not stutter.

Much work has also been done in group psychotherapy with addicted smokers and in treating groups of pregnant women in preparation for painless labor. A later development was the use of group treatment of psychoneurotics with different diagnoses and presenting symptoms, i.e., mixed groups. In the past six or seven years group psychotherapy has begun to be used in rehabilitative work with psychotics.

"True Collective Psychotherapy": Makarenko

While tracing the origins and sources of collective psychotherapy to the pioneering work of Korsakov and Bekhterev at the turn of the century, Soviet psychiatrists consider that true collective psychotherapy began after the Revolution of October 1917 and that a basic contribution to this development was made by the educator A.S. Makarenko.

After the Revolution of 1917 and the civil war that followed it, Makarenko was assigned the task of helping to rehabilitate and reeducate the bands of homeless and parentless youth (the *besprizorniye*) who were roaming the country, many of them engaging in delinquent and criminal activities. Makarenko set up a number of cooperative colonies, where many of these young people were successfully rehabilitated. In the course of this work Makarenko formulated principles of child rearing, education, and rehabilitation that have strongly influenced not only Soviet pedagogy, but also psychotherapy, and especially collective psychotherapy.

On the basis of his experiences with the collectives of *besprizorniye*, Makarenko postulated that the character of the child, and later of the adult, is formed and developed (for better or for worse) in the collective. He felt that human character is determined in large part by the growing child's experiences in relating to significant people in his environment. Makarenko emphasized the role in character formation of the various collectives of which the child was a member, including the family, peer group, school, and the various organizations and institutions of society. The family is the earliest such collective in the child's life. *But the most decisive influence is exerted by the peer group.* (This is a crucial point in Soviet theories and practices of child rearing, education, and psychotherapy.)

Makarenko further emphasized that the impact of the collective, whether it is the family, the peer group in school, camp, or factory, or the therapeutic group, is significant because the collective is the carrier and transmitter of the values and morality of the society. He felt it was important that the child learn, through his actual life experiences in the collective, that his needs and interests are those of the collective, and vice versa. The proper social upbringing of the child, as well as the rehabilitation of the emotionally disturbed person, can best be effected in the collective (3, 4).

Makarenko's ideas strongly influenced Soviet psychiatry. A major criterion of cure in Soviet psychiatry is the restoration of the patient's ability to function as a member of a collective and to engage in socially productive work. The combination of collective therapy and work therapy became one of the hallmarks of Soviet psychotherapy.

Collective Psychotherapy Versus Group Psychotherapy

I had many discussions with my Soviet counterparts about the distinction between true collective psychotherapy and Western group psychotherapy. What I understood them to emphasize was that collective psychotherapy of a group of patients is directly in keeping with the collective spirit of their society. According to the Soviet psychiatrists, collective psychotherapy is a continuation of the everyday life experience and work experience of the patients; i.e., working collectively for a common goal. In the case of the therapeutic collective, the goal is to help each other get well. Furthermore, the collective spirit achieved and reinforced in the therapeutic collective is naturally carried over into the everyday relations of each member of the therapeutic collective.

The Soviet group psychotherapists seemed to be saying that in Western individualist society, there was a contradiction between the attempt to create a collective spirit in the group and the prevailing individualistic, alienated spirit in the surrounding culture and that this contradiction complicated, thwarted, and perhaps distorted the course of group psychotherapy. In the Soviet Union, on the other hand, the collective spirit in the group was facilitated by the collective spirit of the surrounding culture.

In a paper, "A Soviet View of Group Therapy" (5), Professor N.V. Ivanov, Chief of the Department of Psychiatry, S.M. Kirov Institute of Medicine, Gorky, U.S.S.R., stated this proposition thus: "The principal objectives of group psychotherapy abroad—the establishment of more harmonious relationships among human beings—are achieved in our country by our society's organizations, and the fact that man participates in a collective during all periods of his life."

On the basis of this proposition, Ivanov drew the following distinction between Western group psychotherapy and Soviet collective psychotherapy:

In place of the retrospective emphasis of group psychotherapy abroad, the Soviet psychotherapist is concerned with the active mobilization of the personality and its compensatory powers on the basis of the elaboration of new connections, the conditioning of nervous processes, and the objective of creating new, powerful dynamic structures

which, insofar as they are the more powerful, are capable, in accordance with the law of induction, of extinguishing and destroying the pathologically dynamic structures that have given rise to the illness" (5).

One of the psychiatrists whose work in collective psychotherapy I observed described his techniques of "active mobilization of the personality" and of reeducation in terms that closely resemble behavior therapy. He stated:

The basic idea of reeducation consists in creating a real correlation of forces, a dynamic of relationships, which makes it advantageous for the patient to change; in other words, which would give him the incentive to change.

In this connection, I had success with the following device, which is analogous to the developing of a conditioned reflex: I reinforced the positive behavior of the patient by encouragement, praise, and certain rewards. On the other hand, behavior connected with negative character traits was not reinforced, but on the contrary was subjected to criticism and censure in the sessions of collective psychotherapy. In the collective psychopedagogic chats with relatives of the patients, we advised them to pursue the same tactics in the family. We suggested that every manifestation of activity, of concern and attention to the needs of others, of participation in work, should be encouraged, even exaggeratedly; and that antisocial manifestations should be ignored or unanimously censured. Experience has shown that in a series of cases, the systematic application of this technique (in the beginning within the framework of collective psychotherapy, and later at home in the family) substantially corrected many character traits of our patients. But the very best results were achieved when we combined this technique with conscious self-education (6).

Pathogenetic Collective Psychotherapy with Mixed Groups

The type of collective psychotherapy that I observed at the Bekhterev Institute was based on the teachings of V.N. Myasishchev, the fourth of the major contributors to the development of collective psychotherapy. Myasishchev, a pupil of Bekhterev, has during his long professional career formulated and "propagandized" the basic principles of pathogenetic psychotherapy, a form of dynamic psychotherapy that I observed intensively during a 13-month visit at the Bekhterev Institute in Leningrad in 1963-1964. Myasishchev maintains that an uncovering type of dynamic psychotherapy is

the treatment of choice for psychoneuroses and the main modality in the psychotherapist's armamentarium.

However, in contradistinction to psychoanalysis, the therapist in pathogenetic psychotherapy assumes an active role in guiding the direction of the treatment; in giving the patient emotional support, help, and guidance in solving his daily problems; and in reordering his priorities and his values. As Myasishchev puts it, the doctor must be a "teacher of life" to the patient (1). Furthermore, the doctor intervenes actively in the patient's reality situation, helping the patient change those circumstances in his life which the doctor considers to be causative factors in his illness. He may help the patient obtain a change of residence, a change of job, and even a change in profession.

As collective psychotherapy began to be applied more widely in the treatment of mixed groups of psychoneurotic patients, the principles of pathogenetic psychotherapy found application in this area.

The philosophy, theory, and practices of collective psychotherapy in the Soviet Union are related to two basic factors:

1. The motto "Never be a bystander." This means that in any interaction, the citizen who knows what needs to be done is expected and required to instruct, correct, and guide the citizen who has erred. This I observed in 1963-1964 in individual psychotherapy, where the role of the therapist as a teacher of life was very clear (7).

2. The collectivist philosophy, which teaches that the collective life is the best inculcator of values, attitudes, and principles. Therefore, just as in individual psychotherapy, the guiding role of the therapist in the patient-therapist interaction is a natural carry-over into the therapeutic situation of the everyday social attitudes and mores. Thus in the collective psychotherapy setting the group quickly, naturally, and spontaneously assumes the role of a correcting and healing agent. When the personality problem of a given patient is being examined all the other members of the group, no matter how disturbed they may be inwardly, are expected to rally together to guide the member under discussion.

For example, in one group that I observed, a married woman announced her intention never to have any children. She explained her

decision thus: 1) Several years of experience in children's camps had convinced her that all children are monsters and that one can expect no joy out of having them. 2) Life is hard. The world is unjust. And she saw no point in bringing children into such a world.

The group promptly united to persuade this patient that her views were erroneous, that children were the future of the nation and of humanity, that we all have a responsibility to procreate and give our children the best we are capable of, and that surely she must be mistaken in her evaluation of the children in the summer camps.

When asked for my opinion (I was not permitted by the group to be a nonparticipant observer), I suggested that perhaps the patient should be granted the right not to have children, that perhaps there are people who can have a better life without children than with them. The group considered this a provocative statement and reacted to it by turning on me. They accused me of introducing an antitherapeutic note, which, instead of helping the patient overcome her unhealthy stereotype, encouraged and reinforced it. They stated that this was particularly reprehensible coming from a psychiatrist, whose word is a powerful stimulus because it comes from a person with the authority of learning.

It can be seen, then, that the basic philosophical-theoretical orientation and practical applications of collective psychotherapy that I observed correspond, *mutatis mutandis*, to what I observed in individual psychotherapy seven years ago. An effort is made in both settings to elucidate the psychopathogenesis of the symptoms and personality problems (hence the term pathogenetic psychotherapy). But major emphasis is on emotional support, guidance, and reeducation. This emphasis is particularly strong in collective psychotherapy because it is felt that the collective can exert a powerful positive emotional impact on the unhealthy emotional stereotypes and behavior of its members.

REFERENCES

1. Myasishchev VN: *Lichnost' i Nevrozy* [Personality and the Neuroses]. Leningrad, Leningrad University Press, 1960, p 379
2. Korsakov SS: *Kurs Psikhiiatrii* [A Course of Psychiatry], 2nd ed. Moscow, 1901
3. Makarenko AS: *The Road to Life*. Moscow, Foreign Languages Publishing House

4. Makarenko AS: Lectures to Parents. New York, National Council of American-Soviet Friendship, 1954
5. Ivanov NV: A Soviet view of group therapy. *Int J Psychiat* 2:201-212, 1966
6. Libich SS: Personal communication, 1971
7. Ziferstein I: Direct observations of psychotherapy in the USSR, in *Sixth International Congress of Psychotherapy: Selected Lectures*. Edited by Pines M, Spierri T. New York, S Karger, 1965, pp.150-160

Counter-Playing: A Group Therapy Technique

BY JAMES M. KRAININ, M.D.

The author describes a technique he calls "counter-playing," derived from the role of the alter-ego in psychodrama. The therapist, as the counter-player, mimics the posture and actions of his subject and, after developing empathy for the subject (which takes about five minutes), speaks "for" the person, expressing thoughts the subject has for some reason been unable to express. The author finds this technique very useful in resolving impasses and freeing the therapy or group process to move along.

I WISH TO REPORT on a technique that I have used to good effect in group and family therapy and that is, to my knowledge, unknown to most psychotherapists. It derives from psychodrama (1), but it is applicable to any therapy situation in which more than two people are present. In the typical psychodrama arrangement, some persons are assigned roles, and other individuals may play their alter-egos. The technique, which I have labeled "counter-playing," is one that an alter-ego would use. The alter-ego, or as I would call him the counter-player, sits behind and slightly to one side of the subject, out of the latter's field of vision. The essence of what the counter-player does is to mimic every gesture of his subject. (The alter-ego in psychodrama does not necessarily do this.) The counter-player copies hand, body, leg, and

head position. The face cannot usually be seen from this stance. The counter-player finds he experiences the same degree of tension or relaxation that the subject maintains and experiences several other states that I cannot adequately describe. He comes to deepen his understanding of and involvement with his subject. I admit I do not fully understand why.

I have found this method very powerful. It is most useful to me when I counter-play someone with whom I have little empathy. I primarily treat couples; if I find myself siding with one, I utilize this method with the other as subject. I find that in the space of three to five minutes, I strongly feel the pressures to which the subject is reacting. I come to feel I understand why he reacts as he does. Moreover, I find that I can then say things for him: statements and feelings that, for some reason, the subject feels he cannot express in the situation. Generally, such statements are limited to what is going on in the here and now. Often this results in dramatically furthering the progress of therapy or of group process.

The feedback given me has indicated that rarely am I merely projecting my own feelings on the individual but that the thoughts I express are generally thoughts that the other person has consciously held in his mind, but for one reason or another has rationalized against expressing. Both the group and the subject himself come to understand him better. Moreover, the subject is invariably grateful for being helped out of his impasse, for the feeling that he is understood, and for the feeling of support that this provides.

I generally, but not always, say in advance what I am about to do. I state that if I speak

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it will be "for" the other person. Sometimes the context of the situation makes what I do self-explanatory, and I just go ahead. I keep a firm policy of saying nothing until I feel that I am really "into" the subject; this takes about five minutes. I have found that I can successfully teach others to use this technique.

Example

I have chosen an example from a seminar to illustrate the scope of the method's use. A social worker, a young woman, had conducted a family therapy session before a one-way screen to a group composed primarily of psychiatric residents. After the family's departure, the seminar met with the social worker. Members of the group seemed to be trying hard to help her with some unspecified problem. No one could quite tell what had to be dealt with. As a result, the session was stagnant.

I went over to counter-play the social worker. Most of the group soon caught on to what I was doing because we had done some role-playing at other times. As the social worker, I expressed openly my frustration and need, which she had not been able to do. The group began to realize how they had been struggling to do the impossible, since the therapist could not identify what she needed. The group then turned its attention to the family in question rather than to the therapist directly. The therapy session we had witnessed was reenacted in role play, and the seminar session became productive. As this progressed the social worker, with prodding from me, began to recognize and talk about countertransference feelings that she held toward the father of the family, which interfered with her vision of the family and, consequently, with treatment. This process resolved many of the therapist's previously unspecified questions.

Discussion

Birdwhistell (2), Schefflen (3, 4), and others have written about the importance of non-verbal communication. Body positioning and posture comprise an important and usually unconscious method of communicating. Counter-playing has demonstrated to me not only that the body expresses feeling but that using the body in a certain way can, conversely, create feelings and bring to mind thoughts that are appropriate to those feelings in the given context. Use of this method has strengthened my wonder at the interrelationship between mind and body. I encourage those therapists who read this paper with skepticism to try the method out. Of course, it cannot be used unless there are at least three persons in the room, and a conversation of some sort must be started between the other two.

I find that the technique of counter-playing gives me unusual insight into another person's position. Although he and I may have very different personality makeups, sitting with him in a situation and mimicking his gestures causes me to feel much as he does. Being an outsider gives me the freedom to react differently. This allows penetration of resistance and frees the therapy or group process to move along.

REFERENCES

1. Yablonsky L, Enneis J: Psychodrama theory and practice, in *Progress in Psychotherapy*, vol. 1. Edited by Fromm-Reichmann F, Moreno JL. New York, Grune & Stratton, 1956, pp 149-161
2. Birdwhistell R: *Kinesics and Context*. Philadelphia, University of Pennsylvania Press, 1970, pp 99-110, 125-127, 227-238
3. Schefflen A: The significance of posture in communication systems. *Psychiatry* 27:316-331, 1964
4. Schefflen A: Communicational arrangements which further specify a meaning. *Family Process* 9:457-472, 1970

The Effectiveness of Group Psychotherapy in a Correctional Institution

BY CHARLES C. JEW, M.A., T. L. CLANON, M.D.,
AND ARTHUR L. MATTOCKS, PH.D.

The effect of group psychotherapy on 257 inmates suffering primarily from personality and character disorders in a correctional institution is described. Findings based on parole outcome indicated that patients who had treatment did significantly better than controls at one-year follow-up, but the positive effects had disappeared after four years. This suggests the need for crisis intervention with parolees who successfully complete their first year on parole and the development of a program providing continuity of professional service between the institution and the community to sustain the gains made within the institution.

THE CALIFORNIA Medical Facility is a psychiatric institution of the California Department of Corrections whose primary purpose is "the receiving, segregation, confinement, treatment, and care of males under the custody of the Department of Corrections who are either 1) mentally ill, 2) mentally defective, 3) epileptics, 4) addicted to the use of narcotics, 5) otherwise physically or mentally abnormal, including but not limited to psychotic and sex offenders, or 6) suffering from any chronic disease or condition" (1).

Among the programs established for the treatment of these individuals is a group psychotherapy program that, since its inception in 1950 (2), has been providing corrective therapy to those suffering primarily from personality and character disorders and deemed in need of and suitable for treatment.

The goal of the program is to prepare the offender to be more adaptive to the society he will subsequently reenter. But until recently, how well this goal has been achieved has not been systematically determined; whether psychotherapy produced a positive, negative, or negligible effect upon the offender has not been known.

Previous studies focusing on the use of psychotherapy in a correctional setting have been encouraging. Carney and Bottome (3) reported positive results, especially for patients not previously imprisoned. Jesness (4) reported positive but diminishing effects upon delinquents as the period of parole exposure increased. Harrison and Mueller, in a clue-hunting study of group counseling (5), found a significantly lower rate of prison return with the use of stable counseling (participation with one leader for one year or more).

The Problem

The present study is an attempt to determine the efficacy of the group psychotherapy program at a prison psychiatric treatment facility.¹ Specifically, the basic objective is to determine whether institutional group psychotherapy is useful in reducing the rate of recidivism; results are compared with those from a control group receiving no special treatment. The extent and duration of impact, if any, are also being evaluated to determine their relationship to parole outcome.

The Therapy Program

The therapy groups usually consist of eight to ten patients meeting once or twice a week.

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Appreciation is extended to Luke I. C. Kim, M.D., Ph.D., Coordinator of Research and Staff Development, California Medical Facility, for his suggestions.

¹ This study was conducted at the California Medical Facility under the auspices of the California Department of Corrections.

The average number of hours of therapy per patient is approximately eight per month. Sessions are conducted by staff members trained in various social science disciplines such as psychiatry, sociology, psychology, social work, and criminology.

The program during the study period leaned toward a psychoanalytic orientation. The basic concept was toward reorienting or changing the patient's personal adjustment patterns through insight and uncovering processes. Reduction of anxiety levels and assisting the patient toward more constructive use of his assets while he was in the institution were also part of the program. Psychotherapy sessions could vary from highly directive to nondirective approaches, depending on the personal background and training of the therapist. The focus of discussion was generally on anxiety, feelings, and the translation of aggressive, antisocial behavior patterns to more socially adaptable or acceptable ones.

The program was carried on more or less independently of the other parts of the prisoner's program. That is to say, there was no effort to manipulate the total prison environment for therapeutic purposes, nor were the therapists actively involved in the day-to-day program decisions about the patients they treated. There was, however, an overall atmosphere in the institution that was favorable to psychiatric treatment and rehabilitation.

Method

The patient sample was selected from the therapy groups of six therapists between 1958 and 1962. These six included two psychiatrists, two psychologists, and two correctional counselors. The study population was restricted to those treated by the six therapists in order to permit later investigation of the relative effectiveness of different kinds of therapy. Each patient chosen had at least one continuous year of therapy with the same therapist. The choice of the one-year period was based on Harrison and Mueller's finding (5) that the effect of counseling on recidivism could be ascertained only when counseled patients had been in a group led by the same counselor for at least one year. (Many patients in the present study far exceeded this requirement.)

The final size of the sample came to 257.

The patients were in therapy an average of 18 months and had been in prison an average of 40 months at the time of release. Forty percent had prior prison experience; an additional 30 percent had a juvenile record. Most patients did not have a history of narcotic involvement. The majority were white and most were about 30 years of age at the time of treatment.

The patients, all of whom were serving indeterminate sentences, had been judged by the staff of the Department of Corrections at various points of their sentences as requiring treatment. They were referred either by the Reception-Guidance Center's counselors or by the staff at a California Department of Corrections (CDC) institution; they represented a more disturbed population than other CDC inmates, who were thought not to require treatment.

It should be emphasized that these patients were more psychiatrically disturbed than the average CDC felon in that they were chosen through a rigorous selection and screening process. Typically a therapy candidate goes through an evaluation by a sociologist, an examination by a staff psychologist, and an interview by a psychiatrist when this is deemed necessary for concurrence. A final recommendation is made at a meeting of the staff. Although not acutely psychotic, these patients are generally assessed as showing significant emotional problems and a personality disorder that appears to be related to their criminal or deviant behavior. Even when a patient is sent to this institution specifically for this program, he is given further screening and evaluation by the institution's psychiatric staff to determine the final appropriateness of treatment.

The comparison sample ($N = 257$) was chosen by careful matching of BE 61-C² scores (6) from a large sample of inmates released during the 1958-1962 period with those of the experimental sample. Care was

² The BE score factors and the method of deriving the score were as follows:

1. No prior record	10
2. Limited prior record	4
3. This commitment for homicide, assault, or sex offense	6
4. This commitment not for burglary, forgery, or bad checks	2
5. Age 30 years or more in year released	3
6. No history of opiate use	8
7. This is original commitment	1
Total	34

taken to select only those who had not been to the California Medical Facility at Vacaville and had not had group therapy in the Department of Corrections. The BE score² was chosen as the matching device because experience over the past ten years has indicated that the BE is a valid measure of predicting parole outcome for felons in California. The BE 61-C was originally developed and validated by Gottfredson in 1962 (6) to classify inmates primarily for use in studies to determine the effects of differing treatment programs, to help plan programs for inmates, and to improve the ability to predict behavior after release. In addition to the matching of BE scores, the comparison group was further refined through matching on racial and offense characteristics.

The criterion used in assessing the degree of social adaptation and functioning of the patient upon his release from prison is whether or not he returns to prison. "Not return to prison" was used to describe those patients who did not return to prison although they may have been arrested and may have served a jail sentence of fewer than 90 days. "Return to prison" includes any patient who returned to prison with or without a new criminal conviction, was a parolee at large with a felony warrant for his arrest, or was killed in the act of committing a felony or was arrested on a felony charge and was awaiting trial.

Results

One-, two-, and four-year parole follow-ups on the success or failure of the experimental and control groups are presented in table 1. Since the BE score is based on factors demonstrated to be related to parole success, matching the two groups on this measure provides some assurance of the similarity of the experimental and control groups in regard to these factors before the start of treatment. Thus, differences in outcome would be attributable to treatment effects. If the rate of return to prison were significantly lower for the experimental group, this would be an indication of positive treatment effects. Conversely, if the return rate were higher, a negative effect could be inferred.

On a cumulative basis, it is apparent that the experimental group showed a consistently lower number of returns than the control

TABLE 1
Percentages Remaining on Parole
at One-, Two-, and Four-Year
Follow-Up

FOLLOW-UP YEAR	EXPERIMENTAL GROUP (N = 257)	CONTROL GROUP (N = 257)
One	74	67*
Two	55	51
Four	46	44

*Chi square significant at .05 level.

group, beginning with the first and continued through the fourth year of follow-up.

This lower rate of return is most evident in the first year. Chi squares computed for each follow-up period indicate that the rate of return was significantly lower (.05 level of confidence) for the experimental group during the first year, but failed to achieve significance at the second or the fourth year. This finding suggests that therapy has a positive impact upon the patients only for the first year.

The fact that the differences were not significant at the second year was not entirely surprising in view of the phenomenon of "diminishing of treatment effects as a function of increased exposure on parole" found by Jesness (4) and by Rudolph and Bennett (7). At the same time, the high number of returns to prison in the second year suggests that the second year, no less than the first, is a period of difficult readjustment for those who had managed to remain in society. Most importantly, the data suggest that any positive effect from therapy becomes almost negligible by the fourth year; the cumulative number of persons returning to prison was only slightly lower than that from the control group by that time. But considering the total sample, therapy does appear to play a role in delaying the return to prison for some patients.

Discussion and Conclusions

The findings of this study clearly indicate a transfer effect from the prison group psychotherapy program to the parole situation. However, the results strongly suggest that the advantages of the experimental group steadily diminish between the first and second year after release. It may well be that some of the effects of psychotherapy are situationally bound (this is suggested by the fact that a

sizable percentage of those treated return even within the first year, after evidencing sufficient gains to warrant parole), while other effects are time-limited. To use a medical analogy, psychotherapy can perhaps be likened to a penicillin injection: it may help you with a current effort to cope with your problem, but it does not immunize you against all future possibilities.

The implications of our findings support some type of follow-up program for parolees to further strengthen the initial effects of treatment and to extend them beyond the first year or so of community adjustment. In this light it should be emphasized that the present findings represent a population of felons treated by group therapy methods between 1958 and 1962. Since then significant changes have been instituted and the present treatment program contains many innovations; the most relevant of these is outpatient therapy for paroled felons felt to be most in need of such a program. A study based on a more current, larger sample is under way. It will attempt to determine whether these innovations have been successful in extending

the effects of psychotherapy with felon offenders found in the present study.

REFERENCES

1. California Penal Code, section 6102
2. Showstack N: Preliminary report on the psychiatric treatment of prisoners at the California Medical Facility. *Amer J Psychiat* 112:821-824, 1956
3. Carney FJ, Bottome ED: An evaluation of a mental health program in a maximum security correctional institution, Nov 1967 (unpublished manuscript)
4. Jesness CF: The Fricot Ranch study: outcomes with small v large living groups in the rehabilitation of delinquents. Research Report no 47. Sacramento, Calif, Youth Authority Division of Research, Oct 1965 (processed)
5. Harrison RM, Mueller PFC: Cluz hunting about group counseling and parole outcome. Research Report no 11. Sacramento, Calif, Department of Corrections Research Division, May 1964 (processed)
6. Gottfredson DM: A shorthand formula for base expectancies: CDC, BE 61-C. Research Report no 5. Sacramento, Calif, Department of Corrections Research Division, July 1962 (processed)
7. Rudolph A, Bennett LA: The Pico-Project: a measure of casework in corrections. Third Technical Report. Tracy, Calif, Deuel Vocational Institution, 1961 (processed)

EDITOR'S NOTEBOOK

Group Psychotherapy in Perspective

SCIENTIFIC PSYCHOTHERAPY, which originated in Josef Breuer's treatment of Anna O. (1), appears to be completing a highly instructive cycle in its development as the centenary of that case (1880–1882) approaches. In formalizing a method based on Breuer's findings—that talking can be therapeutic, that the verbal expression of feelings has a profoundly beneficial effect, and that the communication of thoughts, feelings, and memories can lead to personality change—Freud was influenced by Breuer's disclosure that he had broken off the case in a state of panic on recognizing the strong reaction the patient was provoking in him. Theoretically, Freud solved the problem of safeguarding practitioners of psychoanalysis from disorganizing embroilments with patients by eliminating the analyst's emotions as a factor in treatment. Rigid adherence to the notion of countertransference as an invariable source of resistance, however, retarded the development of an effective psychotherapy. Breaching the self-defensive rigidity of the classical method in the quest for better results, many psychotherapists have found that feelings for the patient, rather than interfering with treatment, actually facilitate it, provided that the practitioner's behavior is consistently oriented to resolving the obstacles to emotional maturity that emerge in each case. This lesson, evolving from Breuer's therapeutically rewarding albeit traumatic experience, is restoring emotional communication to the armamentarium of psychotherapy.

One modality that has escaped this hobbling is group psychotherapy. It has always drawn on the feelings that group members, serving in effect as cotherapists, develop for one another as an instrument of treatment. But the group therapeutic setting is an exceptionally powerful vehicle for arousing emotions, and how to exploit this force without exposing patients to damaging action is still an unsolved problem. The communication of feelings in language is constructive; venting them in action is destructive (2). Mastery of that distinction is, I believe, one of the crucial tasks confronting the field, for unless emotional action is inhibited, emotional communication fails to achieve its purpose.

Contemporary group therapy demonstrates various symptoms of primitivism. For example, the values, limitations, and goals of each new method reported are rarely delineated; all too often its exponents imply

In this section the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

that it is generally applicable. Failure to give due consideration to the specific therapeutic needs of the patient persists, despite some movement toward specificity (3).

Widespread and diverse forms of experimentation have been conducted during the past decade. The special section in this issue of the *Journal* provides a sampling of new methods and new applications. It also calls attention to a factor that many psychotherapists have denigrated—reliance on external social influences as a therapeutic agent.

The introduction of new techniques and new factors to be controlled may presage a system of group psychotherapy that is firmly grounded in accurate diagnosis and that encompasses specific interventions to resolve the psychotherapeutic problem at hand. Malfunctioning of the human mind cannot be corrected unless one ascertains the developmental level at which it has occurred. Most claims of good results achieved through group treatment pertain to malfunctioning at the oedipal level, which can be corrected with relative ease by many different approaches. But the correction of disturbed functioning at the pre-oedipal level, which is implicated in the severe psychiatric disorders, usually entails highly specific procedures in each case. Therapeutic experimentation in the areas of schizophrenia, psychotic depression, and severe psychosomatic disorders is a pressing need today. Acquisition of the understanding and skills necessary to resolve these conditions consistently and expeditiously would greatly enhance the role of the group psychotherapist in the resolution of the whole range of psychologically reversible disorders that beset mankind.

HYMAN SPOTNITZ, M.D.

REFERENCES

1. Freud S: *Studies on Hysteria* (1893–1895), vol 2, *Complete Psychological Works*, standard ed. Translated and edited by Strachey J. London, Hogarth Press, 1964
2. Spotnitz H: *The Couch and the Circle*. New York, Lancer Books, 1972
3. Spotnitz H: Comparison of different types of group psychotherapy, in *Comprehensive Group Psychotherapy*. Edited by Kaplan HI, Sadock BJ. Baltimore, Williams & Wilkins Co, 1971, pp 72–103

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BRIEF COMMUNICATIONS

Adolescent Maladjustment or Affective Disorder?

BY JOHNNIE L. GALLEMORE, JR., M.D., AND WILLIAM P. WILSON, M.D.

Data were obtained on 35 patients under age 21 from the time they appeared for treatment. All had illnesses compatible with the basic psychological and biological disturbances seen in affective disorders in adults. However, their presenting symptoms were heavily influenced by concerns of adolescence. The data suggest that primary affective disorders are not uncommon in young patients; correct diagnosis and treatment of emotional illness in this age group is important.

ADOLESCENCE is often regarded as a time of anticipated emotional turmoil that may be expressed in a wide variety of behavior. Consequently, when various types of adolescent behavior are brought to the attention of diagnosticians, there is frequently some uncertainty about the presence of recognized medical and psychiatric disorders. Masterson (1) has warned against a tendency to attribute symptomatology found in adolescents to transient developmental turmoil rather than to psychiatric illness; the result may be dangerously delayed therapeutic and preventive intervention. Likewise, what has been said regarding depressive illness in childhood would appear to be equally true of the adolescent years: "The presenting symp-

toms may be deceptive and misleading as they often appear to be physical rather than psychological in origin, or else an alteration in personality in the child is mistakenly attributed to a failure to pull himself together and an unwillingness to accept advice and help" (2).

The question arises then: To what extent does major mental or emotional illness go unrecognized, or to what extent is it subsumed under such categories as "transient situational disturbance" or "behavior disorder of childhood and adolescence" (and is therefore inadequately treated when it occurs in the setting of "typical" or intense adolescent conflict and coloring)? It is possible that these expected "struggles" might be incorporated into an illness and result in unusual presenting symptomatology.

The early onset of a schizophrenic illness, the "dementia praecox" of Morel and Kraepelin, has been well described. Relatively little attention, however, has surrounded the presence of affective disorders in the adolescent age group. Articles can be found that describe depression, anxiety, and elation in young patients, but psychodynamic rather than diagnostic aspects have been primarily emphasized (3-5). Some published data about suicide, however, suggest that severe affective psychoses frequently occur in teen-agers and young adults (6-9). Furthermore, Kraepelin reported that the time when the greatest number of first attacks of manic-depressive illness occurs is in "the period of development with its increased emotional

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This section includes articles that are usually, although not always, less lengthy than the preceding articles. Included are clinical notes, case reports, historical notes, and other material selected by the Editor. In general, articles submitted for this section should be no longer than eight double-spaced typed pages.

excitability between the fifteenth and twentieth year" (10, p. 167). Nevertheless, few reports have carefully scrutinized presenting symptoms in an effort to identify and to describe the occurrence of primary affective disorders in the adolescent age group and setting.

We have been impressed that a significant number of individuals in a large population of adults with affective disorders have described similar episodes of illness in their adolescent and young-adult years. Also, an increasing number of adolescent patients have appeared with illnesses that, when viewed retrospectively, have been found to be benign and self-limited, with a definitive onset and full functional recovery. Many of these illnesses were characterized by primary, severe disorder of mood and by disturbed thought and behavior consonant with the affect, although the presenting symptoms frequently differed from those typical of affective disorders of later life. Many patients were referred because of apathy in school or in family life, restlessness, wanderlust, or philosophizing—so often attributed rather resignedly to the "teen-age personality." Temper outbursts, sexual promiscuity, and mild megalomaniac behavior also led to referral, often with a diagnosis of "adjustment reaction of adolescence." In an effort to better characterize such a group of patients, a prospective study was devised.

Method

Thirty-five patients under 21 years of age, who appeared at a university medical center, were extensively studied from the time of presentation for treatment. Age 20 was arbitrarily determined as the maximum for inclusion in the study, although the entire patient population was regarded as "adolescent" in that none were emancipated and independent adults. Only illnesses compatible with affective disorders as described in the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (11) and with the basic criteria we have outlined here were included in the study. Subgrouping was not attempted.

Data sheets were designed in order that a multifactor computer analysis could be carried out. Each of the patients was personally examined, using a structured interview and available accessory anamnestic sources, to

TABLE 1
Distribution of Patients by Age and Sex

AGE	MEN	WOMEN
15	2	C
17	1	C
18	5	C
19	11	C
20	12	C
Total	31	C

clearly establish the diagnosis and to obtain the necessary information. Data relevant to precipitating factors, the variety of affects present, preoccupations, biological functions, personal history, and phenomena of the illness were recorded. These data were then summarized and analyzed.

Results

The age and sex distribution of the patients studied is shown in table 1. The average age of the group was 18.8 years. All patients were Caucasian. The predominance of men in the study reflects the sample that appeared at the time of the study. The one married patient, a woman, had been wed less than one year. Socioeconomic backgrounds varied.

At the time of their first interview, none of the patients had been previously hospitalized for psychiatric illness, although five had undergone some treatment for a similar illness. Only 12 patients had been ill as long as six months, and nearly half of the remainder had obtained psychiatric treatment within three months from the onset of their illness. This supported the belief that symptoms of relatively acute onset in affective disorders tend to bring patients (even younger ones) to treatment in the early phase of the illness.

In just over half of the patients, no precipitating factors could be implicated. Among the others a broad scattering of factors included separation from the family in two patients, illness in one, job loss in one, and military induction in one. A number of patients attributed the onset of their illness to incidents at school and to academic performance.

A group of basic affects has been previously identified and described (12). Each patient in this study was examined for the presence of the most pervasive, disturbed affect, as well as for concomitant disturbance of any of the others (see table 2). Nine patients ex-

TABLE 2
Primary and Concomitant Affects Disturbed

AFFECT	PRIMARY	CONCOMITANT
Depression	25	9
Elation	5	3
Anger	1	17
Awe	1	4
Confusion	0	16
Shame	0	9
Emptiness	1	4
Pain	0	3
Fear	2	14
Suspicion	0	1
Disgust	0	3

hibited as many as five pathologically intense affects. Including concomitant occurrence, depression was present in all but one patient. As concomitantly disturbed affects, anger appeared in nearly half, and confusion and fear appeared in over one-third. Fifteen patients described a diurnal variation of mood.

Biological changes in patients with primarily excitatory affects (awe, elation, anger) and with primarily inhibitory affects (all others) are summarized in table 3. Over half of the patients in each category experienced a decrease in sleep and in appetite. Sexual libido and potentia were for the most part unaffected by the illness. Psychic activity in both groups was primarily increased, manifested mostly by pressure of thought and difficulty in concentration. Eight of the 25 patients described having some complaint with memory. Perceptual changes were uncommon (see table 4).

Primary preoccupations are summarized in table 5. By far the greatest number of patients were most concerned with personal failure. Not surprisingly, all of these patients were primarily depressed. Interestingly, none of the patients were preoccupied with somatic concerns, in contrast to findings in a large number of adults with affective disorders.

Just over half of the patients denied suicidal thoughts or intents. The remainder were

troubled with frequent thoughts of suicide: three of these made suicidal attempts, one with an overdose of drugs and two with cutting instruments. Eleven patients had illnesses that were judged to render them at least 75 percent nonfunctional at the time of the initial study. Most of the remainder were felt to have only mildly impaired functioning.

Lengthy follow-up studies of this patient group have not yet been possible. However, over a period of less than two years the majority of patients have responded well to the treatment modalities of choice, including individual and group psychotherapy, medication, and electric shock therapy. In most cases, resumption of usual activities has been possible at the premorbid level.

Case Reports

Two case reports are illustrative of the patient group studied.

Case 1. A 19-year-old single college student who was normally quiet but well-liked became increasingly excited following a dormitory bull session in which he was accused of lying about grades. Over a period of several days he became restless and hyperactive, talked incessantly, and began preaching the love of God. He frequently shouted and was obviously elated, but also exhibited fear, anger, and confusion. Severe insomnia and anorexia were noted. Despite much preoccupation with sex, he had no change in libido and potentia. The patient was brought to the hospital by his dean. After hospitalization for 18 days and treatment primarily with medication, he was able to resume classes. Since that time he has been predominantly euthymic but has had transient periods of mild depression.

Case 2. A 15-year-old single high school student who had been active in football and had performed well academically became increasingly concerned with personal failure over a four-month period. He felt that everyone around him was arbitrarily critical of him. His symptoms

TABLE 3
Biological Changes Associated with Excitatory and Inhibitory Affects

BIOLOGICAL FUNCTION	EXCITATORY AFFECTS			INHIBITORY AFFECTS		
	INCREASE	DECREASE	NO CHANGE	INCREASE	DECREASE	NO CHANGE
Sleep	1	6	0	6	14	8
Appetite	0	5	2	2	15	11
Libido	0	1	6	1	7	20
Potentia	0	1	6	0	3	25
Motor	4	1	2	5	16	7
Psychic	7	0	0	23	3	2

TABLE 4
Perceptual Changes Associated with Excitatory and Inhibitory Affects

SENSE	EXCITATORY AFFECTS		INHIBITORY AFFECTS	
	CHANGE	NO CHANGE	CHANGE	NO CHANGE
Vision	1	6	6	22
Touch	1	6	2	26
Smell	1	6	1	27
Taste	1	6	2	26
Hearing	1	6	1	27

included frequent crying, introspection, increased appetite and weight, intermittent insomnia, and loss of energy; he often felt "just like leaving home" and "I might as well be dead." He lost interest in football. He was brought for psychiatric consultation when he challenged his parents with, "If you don't like the way I am, why don't you take me to a psychiatrist?" Interestingly, his father had had a history of repeated hospitalizations for mood disorders, finally achieving stabilization with lithium therapy.

Discussion

In a retrospective study of 65 hospitalized adolescents six years later, the largest single diagnostic category found was that of affective disorder (40 percent) (13). While not widely supported in the psychiatric literature, this finding and the data given here suggest that affective disorders nevertheless occur frequently in the adolescent age group, perhaps being unrecognized or classified in other ways. King and Pittman (13) found a nearly uniform outcome for their affectively disturbed patients, whose symptoms remitted, but stressed the diagnostic value of longitudinal evaluation of patients since cross-sectional assessments yield a variety of patterns. While a longitudinal study of the patient undoubtedly does provide important confirmatory information, the data presented here suggest that adolescents with primary affective disorders can be recognized at the time of

presentation for treatment if the clinician is alert to the manner in which dependent relationships, youthful conflicts, and preoccupations may color the symptoms encountered.

It appears that the basic illness differs little in adolescents from that in older patients. The natural history of affective disorders in adults is well known. Additionally, the retrospective follow-up study of hospitalized adolescents indicates a favorable prognosis for the illness regardless of age (13). However, it is apparent that age at onset does influence the presenting clinical picture. In contrast to the data cited here, a study of a large number of adults indicated that precipitating factors were more likely to be implicated and to more often involve the loss of a significant person, illness, injury or surgery, or a change in occupational status than in youth (14). In the area of biological function, the disturbance of sexual libido and of potentia and retardation of psychomotor processes were more likely to be found in adults.

In differentiating "normal" adolescent behavior from various forms of age-related maladjustment, it is important to consider acuteness of onset of presenting symptomatology, duration and intensity of symptoms, persistence of symptoms in relation to relief of stress, past history and family history of the individual, course of the illness, and response to treatment. Many young patients are seen by student health and military physicians who may not be oriented to the various manifestations of emotional illness in this age group. Unfortunately, many residency training programs have given their trainees little exposure to adolescent psychiatry.

It is apparent that decisions made in the early years when the individual is ill will prejudice later choices. Despite the generally favorable outcome of affective illness, the patient's future may be at stake in the selection of a mate or a career, in the continuation of education, and in an orderly progression

TABLE 5
Primary Preoccupations

PREOCCUPATION	MEN	WOMEN
Sexual	2	0
Salvation	2	0
Social	1	1
Sanity	4	1
Occupational (educational)	3	0
Personal failure	10	1
Other	3	0
None	6	1
Total	31	4

toward life goals. Also, the frequency of suicide among causes of death in the 15-to-19-year-old population in this country must not be overlooked (8).

The time seems overripe for developing a more definitive and uniform classification of mental and emotional disorders occurring in adolescence. The determination of correct prognosis and appropriate treatment must be based on proper diagnosis. Experience with the patients studied indicates that age alone should not dictate the choice of treatment. The hazards of undiagnosed and untreated mental illness should issue a clear challenge to those undertaking the care of adolescent patients.

REFERENCES

1. Masterson JF Jr: Psychiatric significance of adolescent turmoil. *Amer J Psychiat* 124:1549-1554, 1968
2. Frommer EA: Treatment of childhood depression with anti-depressant drugs. *Brit Med J* 1:729-732, 1967
3. Faux EJ, Rowley CM: Detecting depression in childhood. *Hosp Community Psychiat* 18:51-58, 1967
4. Enzer N, Walker P: Hyperventilation syndrome in children. *J Pediat* 70:521-532, 1967
5. Elson M: The reactive impact of adolescent and family upon each other in separation. *J Amer Acad Child Psychiat* 3:697-708, 1964
6. Otto U: Changes in the behavior in children and adolescents preceding suicidal attempts. *Acta Psychiat Scand* 40:386-400, 1964
7. Kessell N: Self-poisoning: part I. *Brit Med J* 2:1256-1270, 1965
8. Bawkin H: Suicide in children and adolescents. *J Pediat* 50:749-769, 1957
9. Toolan JM: Depression in children and adolescents. *Amer J Orthopsychiat* 32:404-415, 1962
10. Kraepelin E: *Manic-Depressive Insanity*. Translated by Barclay RM. Edinburgh, E & S Livingstone, 1921
11. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 2nd ed. Washington, DC, APA, 1968, p 35
12. Hohman LB, Wilson WP: The varieties of affective disturbances. *Southern Med J* 55:307-309, 1962
13. King LJ, Pittman GD: A six-year follow-up study of 65 adolescent patients: natural history of affective disorders in adolescence. *Arch Gen Psychiat* 20:230-236, 1970
14. Gallemore JL Jr, Wilson WP: Precipitating factors in affective disorders. *Southern Med J* 64:1248-1252, 1971

Physician Use of Marijuana, Alcohol, and Tobacco

BY MARTIN R. LIPP, M.D., AND SAMUEL G. BENSON, M.D., PH.D.

The authors questioned 1,314 physicians (chosen at random from four geographical areas) concerning their use of and opinions about marijuana. Thirty-seven percent had been exposed to marijuana, 25 percent had used it, and seven percent were using it currently. In general, experience with cannabis varied with age and location. When queried about their use of alcohol and cigarettes, only eight percent of the subjects were teetotalers and 21 percent currently smoked cigarettes.

MARIJUANA IS a continuing source of controversy within the medical profession and society as a whole. Study after study reveals increasing use by students, soldiers, and others (1-3).

Our group became interested in marijuana

(cannabis) use among medical personnel for two reasons. First, the marijuana issue is presumed to be at least in part a medical issue. Most discussions of the status of marijuana include information about medical and psychiatric effects. The anxious parents of young patients often regard doctors as "ex-

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perts" on the subject. Therefore, knowledge about the opinions and particularly the practices of medical personnel could be useful in influencing the use of marijuana in the general population.

Second, the generation gap has long been loudly proclaimed, and marijuana seems to be an important symbol for the youthful side of the gap. Does marijuana use mark the existence of such a generation gap within the health professions?

For these reasons, we undertook a detailed study of social drug use and of opinions among students and graduates in both the medical and nursing professions. This paper reports data gathered from graduate physicians. Relevant information from previously published surveys on medical students (4, 5) and on nursing students (6) will be included in the discussion to follow.

Method

Some 2,652 questionnaires were distributed and retrieved by the Department of Survey Research of the American Medical Association in the early months of 1971. The physicians in our study were selected randomly from AMA rosters in the areas of New York City, upstate New York, Nebraska, and the San Francisco Bay area. These areas were specifically chosen to allow us to compare data on physicians with data we had previously gathered, using the same questionnaire and research protocol, on medical students at New York University, the State University of New York at Buffalo, the University of Nebraska, and Stanford University.

All questionnaires were strictly anonymous and were distributed and returned by mail. (The nature of the questions asked will become clear in the presentation of the data.) Included with each questionnaire was a cover letter that stressed the importance and confidential nature of the project. Since respondents were not identifiable, no follow-up of nonrespondents was attempted.

Distribution of the questionnaires was completed in early February 1971, and the retrieval of responses was concluded by the end of March 1971. Of the 2,652 questionnaires distributed, 1,314 were returned. The rate of return in the four areas varied from 47 to 53 percent.

Results

Cannabis. Overall, 37 percent of the respondents indicated that they had been exposed to the use of cannabis ("... in a room or at an event where others have used marijuana"). Approximately 25 percent had tried the drug at least once, and seven percent identified themselves as current users.

However, these cumulative figures mask considerable diversity in use, which becomes apparent when the data are plotted by age and by geographical area. Table 1 divides the respondents in each area according to age and lists those who are currently using the drug, those who have used it in the past but are no longer using it, and those who have never used it. Figures from previous studies on medical students are included for comparison.

There were significant differences in cannabis usage associated both with age and with geographical area. In general, the younger age groups were more likely to have tried marijuana in the past and to be using it currently. This age-use relationship was highly significant in all areas except Nebraska, where the low number of past users ($N=9$) and of present users ($N=3$) precluded good statistical comparisons.

The San Francisco Bay and New York City areas showed considerably greater numbers of users than Nebraska and upstate New York; these differences were highly significant ($p>.001$). However, no significant age-related differences were detected between the two areas of higher use, New York City and San Francisco.

Alcoholic beverages. Among all respondents, only eight percent were teetotalers. This figure varied from a low of six percent in New York City to a high of 13 percent in Nebraska. However, within any given age group, the differences among areas were not significant, nor were there significant age-related differences within any given area. The term "alcoholic beverage" here does not distinguish among beer, wine, or hard liquor and is intended only as a rough index of the respondents' use of a socially sanctioned drug of known pharmacological consequences.

Cigarettes. The respondents were asked to indicate how many packs of cigarettes they smoked each month. On the average, 21 percent of the physician-respondents currently smoked cigarettes, with a high of 29 percent

TABLE 1
Marijuana Use by Age and Geographical Area (in Percentages)

GROUP	NUMBER	CURRENT USERS	PAST USERS	NEVER-USERS
San Francisco Bay Area				
Medical students	213	44	26	30
Physicians				
under 35	71	27	30	44
35-39	105	11	24	65
40-44	105	8	24	69
45 and older	94	2	23	75
Upper New York State area				
Medical students	251	26	20	54
Physicians				
under 35	43	9	9	81
35-39	105	2	11	88
40-44	105	0	5	95
45 and older	96	2	1	97
New York City				
Medical students	367	42	26	32
Physicians				
under 35	57	19	21	60
35-39	77	17	26	57
40-44	82	5	22	73
45 and older	82	5	15	81
Nebraska				
Medical students	226	6	10	84
Physicians				
under 35	39	5	5	90
35-39	78	0	3	97
40-44	88	1	5	94
45 and older	87	0	1	99

in Nebraska and a low of 16 percent in upstate New York. There was an apparent age-related trend in cigarette use, the youngest groups most likely never to have smoked, the oldest groups to have smoked in the past but quit. However, this relationship was statistically significant only for the upstate New York group. Overall, 40 percent of the respondents had smoked in the past but had quit. Among our respondents the use of cigarettes in the past or in the present was not related in any significant way to the use of marijuana.

Medical opinion. Our questionnaire asked each respondent to indicate which one of a series of statements most closely paralleled his opinion with regard to the appropriate medical status of cannabis. The highest percentage (40 percent) indicated: "... relatively harmless in milder forms; should be graded according to strength and subjected to controls accordingly." The second most numerous choice (22 percent) was "... research only." Others indicated "no human use" whatsoever (15 percent); "no opinion" (10 percent); "... relatively harmless ... should be made available to the public without restriction" (6 percent); individual use "should be decided by a professionally trained per-

son" (4 percent); and "no medical considerations" (3 percent).

These opinions were highly correlated with marijuana use. Of the 78 physicians who took the most permissive stand ("should be available ... without restriction"), 78 percent had been exposed to marijuana use, 58 percent had used it, and 24 percent were currently using it. Of the 201 who were the most restrictive (not for human consumption), 98 percent had never used marijuana, 84 percent had never been exposed to it, and none was a current user. Intermediate opinions correlated with intermediate experience.

Sources of information. The physicians were asked what one or more sources they valued in forming their *medical* opinions about cannabis. Professional reading was the most popular (73 percent), followed by mass media and nonprofessional reading (42 percent), and experience with patients (33 percent). Less valued were recognized authorities (23 percent), friends and peers (23 percent), college-age and younger acquaintances (14 percent), and personal experience (12 percent). Least valued were formal teaching (6 percent) and laws and court decisions (5 percent).

Projected changes in cannabis use. The

physicians were asked to indicate how their use of marijuana would change under various medical and legal contingencies. Four questions were asked.

1. Assuming that the legal status of marijuana remains unchanged and that marijuana is found to be totally harmless and as good a euphoriant as alcohol, with what frequency could you reasonably expect yourself to use marijuana?

2. Assuming that the legal status of marijuana remains unchanged and that marijuana is found to be as good a euphoriant as alcohol, with long-term effects identical to those of cigarette smoking, with what frequency could you reasonably expect yourself to use marijuana?

3. Assuming that *your* medical opinion of marijuana remains unchanged and that the legal penalty for marijuana use is reduced to the level of a misdemeanor, with what frequency could you reasonably expect yourself to use marijuana?

4. Assuming that *your* medical opinion of marijuana remains unchanged and that legal sanctions against marijuana are reduced to penalize only illegal behavior while under the influence (e.g., similar to the laws concerning alcohol), with what frequency could you reasonably expect yourself to use marijuana?

The groups in the four areas responded similarly to the hypothetical situations, each projecting greater usage (compared to current usage) in all situations. The greatest upward projected change in cannabis use occurred with hypothetical situation 4 (26 percent), then 1 (21 percent), then 3 (14 percent), then 2 (11 percent). When we divided the respondents in each area into "users, experimenters," and "never-users," we found considerable variation within each area—but again the kinds of changes were parallel for each group in all areas.

If the legal sanctions against marijuana use were considerably relaxed, some who had never used marijuana predicted that they would become users, but most of them did not expect to become users in any of the projected situations. The experimenters indicated considerably more interest in using marijuana in all situations. If only aberrant behavior were penalized, a majority of the experimenters would have increased their use of cannabis. In contrast, if cannabis were found to have long-term effects equivalent to those

of cigarettes, relatively few experimenters would have resumed cannabis use.

In almost all cases, a majority of the users would have maintained their current level of marijuana use regardless of the projected conditions. A small percentage would have decreased their use in each case, with a somewhat larger group indicating an expected increase in usage. This pattern was changed in situation 2, in which a greater proportion of respondents expected to decrease their use.

Discussion

The marijuana issue sometimes seems so highly charged that an attempt at a sober and thoughtful discussion of these data may be more illusory than real. We certainly have our own "medical opinions," which, like those of our respondents, are highly correlated with our own exposure to and experience with cannabis.

The conclusions drawn from this paper will surely vary with readers' experiences and preconceptions. There will be differing opinions about the generalizability of this survey, and appropriately so. However, these opinions should not obscure the fact that this is a report of 1,314 physicians who chose to tell us about their experiences and opinions. No one can say whether they exaggerated or minimized or lied. No one can report whether the 1,338 physicians who did not respond had back because of lack of interest or fear or some other reason. Given the limitations of mailed questionnaire surveys, information (from a large sample of a large population) that may put a person in legal jeopardy simply is not available in any other way. With this in mind, the research protocol was as rigorous as we could make it.

It seems to us that the most important information to be drawn from this study is that in our sample use of and opinions about marijuana varied significantly with age and geography. This is not an isolated finding. We found the same type of variation in our nursing studies (6). Any cursory review of dozens of high school, college, and Gallup Poll reports will substantiate this general trend (7).

But this fact takes on special significance in the medical profession. We cannot simply call all marijuana users stupid or immature

or crazy. No one has yet demonstrated any correlation between doctors' use of marijuana and their IQ or psychiatric diagnosis.

What does all this mean? Most important, these data imply that the marijuana issue, as well as being a scientific issue, is very much a cultural issue, even among physicians. People in the health professions are ultimately creatures of our time, perhaps no more or less able to resist social phenomena than their neighbors and patients. Physicians must soon come to grips with the fact that they themselves use marijuana and must cease talking about marijuana use as something that occurs only among adolescents and patients.

If medical authorities cannot convince physicians to refrain from trying or using marijuana, convincing the public at large seems unlikely.

REFERENCES

1. Bass D: The pot-smoking UC law students. *San Francisco Chronicle*, Oct 27, 1969, p 1
2. Blum RH and associates: *Students and Drugs: College and High School Observations*. San Francisco, Jossey-Bass, 1969
3. Pot-smoking in combat—Army study. *San Francisco Chronicle*, Apr 4, 1970, p 1
4. Lipp MR, Benson SG, Taintor Z: Marijuana use by medical students. *Amer J Psychiat* 128:207-212, 1971
5. Lipp MR, Tinklenberg J, Benson SG, et al: Medical student use of marijuana, alcohol and cigarettes: a study of four schools. *International Journal of Addictions* 7:141-152, 1972
6. Lipp MR, Benson SG, Allen P: Marijuana use by nurses and nursing students. *Amer J Nurs* 71:2339-2341, 1971
7. Berg DF: *Illicit Use of Dangerous Drugs in the United States: A Compilation of Studies, Surveys and Polls*. Washington, DC, Bureau of Narcotics and Dangerous Drugs, Sept 1971

The Attitudes of Patients and Their Trainee Therapists Toward Participation in Psychiatric Board Examinations

BY HERBERT H. EVELOFF, M.D., AND CHARLES P. MCCREARY, PH.D.

The authors examined the attitudes of patients and of trainee therapists toward the participation of patients in an examination of the American Board of Psychiatry and Neurology. Neither the therapists nor the patients reported any serious untoward consequences. The patients reported a slightly positive effect and the therapists a slightly negative one, although neither trend reached statistical significance.

OUR INTENTION in this study was to examine the effect of the examinations (psychiatry part only) of the American Board of Psychiatry and Neurology on participating patients and their trainee therapists.

The impetus for undertaking this pilot

study arose from our concern, amplified by those of colleagues and trainees, that patient participation in Board examinations might in some way harm the patients, their relationship with their doctor, or the therapeutic process. Although one could argue that participation in the examinations by both patients and trainees is customarily voluntary (thereby automatically eliminating most potential problems), there was a remaining concern that some aspects of context or personality might render the request to participate much less voluntary than it is intended to be. For instance, the patient might fear discharge from the hospital or from the outpatient department of the clinic if he did not comply, or the trainee might be apprehensive about some future censure from superiors for appearing uncooperative.

Therefore, since the examination of patients by prospective diplomates appears to be an integral part of the Board procedure and is likely to be retained for some time, it

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seemed important to assess the "cost," if any, to the patients' welfare and/or to the treatment process.

The specific Board examination studied was that held at the UCLA Neuropsychiatric Institute, Sunday, Dec. 13 (written examination only), through Tuesday, Dec. 15, 1970.

Each clinical examination consisted of an examinee's 30-minute interview of a patient, usually in the presence of one or two examiners. Most patients agreed to be examined more than once and were called on for an average of two or three sessions with half-hour rest periods between each examination. The patients' trainee therapists were not present but were available on call.

After a three-month period—one judged sufficiently long to permit an evaluation of possible lasting effects—the trainees and patients were asked to complete questionnaires assessing their attitudes and responses.

Method

The study was designed to assess: 1) the trainee's attitudes toward the Board exams, 2) the effects of the examinations on the patients as reported by their trainees, and 3) the effects of the examinations on the patients as reported by the patients themselves.

Assessment of Trainee Attitudes

Questionnaires about their attitudes toward the examinations were sent to 87 trainees in the Department of Psychiatry at the UCLA Neuropsychiatric Institute. Of these, 54 were first-, second-, and third-year psychiatric residents; 25 were advanced residents in legal, child, and community psychiatry; and eight were predoctoral clinical psychology fellows. Forty-one trainees responded. Three means of assessing the attitudes of the trainees toward the examinations were used in this study. One method consisted of having the trainees complete an eight-item, true-false questionnaire containing statements about the examinations. Three faculty members of the Department of Psychiatry rated each statement as to whether it reflected a positive or a negative opinion. The ratings of the trainees were summed, and a score was derived that reflected their attitude on a positive-negative continuum. The second method involved asking the trainees to directly rate their attitudes toward the Board examina-

tions as a means of determining psychiatric competence. The trainees rated their attitudes on a seven-point scale that ranged from 1 ("totally useless") to 7 ("best means possible"). For the third method each trainee was asked to write narrative comments about his attitudes toward the examinations.

Effects of the Examinations on Patients as Reported by Trainees

Of the 41 trainees who responded to our request for participation in this study, 27 actually referred from one to four patients. These 27 trainees were given a multiple-choice questionnaire in which they were asked to rate: 1) their impressions of the benefit or harm of the examinations to their patients, 2) the effect of the examinations on the course of therapy, 3) the amount of encouragement they gave patients to participate in the examinations, 4) their willingness to submit patients to any future Board examinations, 5) their estimation of the effects of the examinations on colleagues' patients, and 6) their expectation of the effect on their patients prior to the examinations. In addition to these ratings, each trainee was asked to supply a narrative description of his impressions.

Effects of the Examinations on Patients as Reported by the Patients Themselves

The 27 trainees who actually referred patients contributed a total of 61 patients (30 inpatients and 31 outpatients). Of the 61 patients who were sent questionnaires, 34 (56 percent) responded.

The questionnaires were in the form of a multiple-choice inventory. The patients were asked to rate: 1) their eagerness to participate, 2) their like or dislike of each candidate who examined them, 3) what they felt was the effect of the examinations on their own therapy, 4) their experience (i.e., pleasant versus unpleasant) during each examination, and 5) their willingness to participate again.

If a patient was examined by more than one candidate (as was true in the majority of cases), he was asked to rate each candidate separately. In addition, the patient was asked to register overall global ratings.

An analysis of the effects of the examinations was done by averaging the responses of each patient.

Finally, each patient was encouraged to write a narrative description of his im-

pressions of the experience, its effects on him and on his therapy, and whatever additional information, suggestions, etc., he might wish to convey.

Discussion

Both therapists and patients reported that the examinations neither harmed nor benefited therapy. In fact, the patients reported a slight overall positive effect on therapy (mean = 3.2, where 4 = no effect and 3 = mild benefit). Patients reported that the examinations neither harmed nor benefited them personally, that is, apart from the therapeutic process itself. As stated before, they tended to report their experience as somewhat beneficial, although this was not a strong inclination (mean = 2.2, where 2 = a "moderately pleasant experience").

The narrative comments tended to support these findings, derived from scoring the data obtained on the questionnaire, namely, that in general patients did not report any serious or lasting deleterious consequences from participating in the examinations. We will cite several characteristic comments made by patients. Note that only one patient reported any appreciable discomfort at the time (see comment 6, which was by far the most negative of all). Most of the negative comments concerned the logistics of the examination (e.g., too short, people coming in and going out, etc.) or the anxiety of the examinees. In general, the patients felt the experience was helpful and interesting and indicated that they were glad to have had an opportunity to make a contribution.

1. "The poor men seemed so nervous that I was wondering in what way I might help them."

2. "I wouldn't mind being in another one. I feel it was fairly helpful to me but I wish the exam lasted a little longer. I believe that talking to different people about my problems usually helps me in finding an answer, or in actually finding out what the real problem is."

3. "I hope that this will be of benefit to improve the quality of psychiatric care."

4. "I found it fun."

5. "Even though I found them mildly unpleasant, I think I benefited from the experience."

6. "It was very difficult talking to strangers

that didn't know my case history and also very painful at times."

The therapists' ratings of the benefit or harm of the examinations to their patients were significantly correlated both with their patients' willingness to participate in future examinations and with their scores on whether the experience was pleasant or unpleasant ($r = .47$, $p > .01$). However, the patients' ratings of liking as opposed to disliking the experience were not correlated with their ratings of the effect of the examinations on therapy. Thus, the therapists had a direct influence on their patients with respect to whether or not they were going to enjoy the examination experience and/or participate again. However, this influence did not extend to coloring the patients' appraisal of the seemingly more significant variable—the effect on therapy.

The therapists' ratings of the overall benefit or harm of the examinations were not correlated with the patients' ratings, the patients tending to view the examinations in a more positive light. This may mean that the therapists were under more stress by their patients' participating in the examinations than the patients themselves.

Neither the patients' nor the therapists' ratings of the effects of the examinations on therapy were correlated with the patients' willingness to participate again. The patients generally seemed willing to offer themselves for examination independently of their therapists' concerns or even of their own evaluations on the potential effect on treatment. Again, this may mean that the therapists were more worried about the examinations than the patients; apparently the patients were willing to take the risk. One possible conclusion is that patients did not view themselves as being as fragile as the therapists did.

There was a significant correlation between the therapists' attitudes regarding the examinations and whether or not they referred patients. Those who referred patients ($N = 27$) had a mean score of 5.07 on a scale of 1 (useless) to 7 (valuable), while those who did not refer patients ($N = 14$) had a mean score of 2.64.

The not-too-startling fact that those who were more sanguine toward the Board examinations tended to be those who referred patients may well have weighted patients'

reports in the positive direction. This seemed to be particularly the case since, as noted, the therapists' attitudes toward the examinations influenced the patients' attitudes toward them. In short, our suspicion is that patients tended not to have adverse reactions in part because those therapists who might have been the most likely to negatively influence patients automatically eliminated themselves.

Lastly, with respect to their opinion of the value of the Board examinations in determining psychiatric proficiency, the overall rating of the entire responding trainee group ($N = 41$) was 3.42. This was slightly to the "useless" end of the scale. We found this mildly negative rating surprising; we had expected a much stronger negative rating in view of the acidic nature of spontaneous comments made before the examination, as well as of those registered on the questionnaires.

Several sample narrative comments that appeared on the questionnaire follow:

"I feel the establishment of a diagnosis and the discussion of the clinical syndrome is not a measure of a real psychiatric skill but only represents a minimal intellectualized performance in a situation of greatly elevated anxiety."

"Board examinations are superfluous and remove qualification assessment from where it should belong; i.e., in the hands of training institutions. These institutions to receive approval should be competent to prepare and *responsible* enough to judge qualified psychiatrists."

"1) About the Boards as an indicator of qualification—anyone with the capacity for rote, the skin of a pachyderm and the equanimity and creativity of a robot could pass—but might be a lousy psychiatrist; 2) A workable alternative is the recommendation of the educating institution who have a far greater understanding of the individual and his potential; 3) Research and other nobler pseudo-incentives notwithstanding, why should we invent a new stress in an already stress-overladen world for the reconstituting patient."

In evaluating such comments, several factors should be kept in mind, specifically those involving the patient population, the trainees who referred patients, and the setting in which the Board examinations were held.

The Patient Population

First, the patient population in this institution may have been less disturbed than that in other institutions which have hosted the Boards. At the time of the examinations, only voluntary patients were admitted to the inpatient service for an average stay of less than 90 days. The outpatients were generally drawn from the west Los Angeles area and its immediate environs. These patients tended to belong to the lower middle class and middle class and had a somewhat better financial status, educational background, and level of sophistication than those attending other clinics located in deprived areas.

Every effort was made to make the patients feel welcome and appreciated. Although they were not paid to participate, they were compensated for travel costs, baby-sitters, etc. Lunch and refreshments were provided at no cost to the patients, and volunteers and professionals were available in the waiting room to meet their needs. These patient-related factors may well have contributed significantly to the slightly positive overall response that most patients reported with respect to their participation in the examinations.

The Trainees

In our view the trainees involved were, for the most part, bright, self-motivated, independent young men and women. Characteristically, they relied very heavily on their own evaluation of the demands made on them, rather than dutifully following staff requests. Our feeling is that, at the time, trainee compliance to administrative fiat was at a low point; they participated only if they chose to. Our results supported this latter contention. They showed that those trainees who were most antagonistic to the concept of Board certification, and therefore to the concept of the examination procedure, tended to select themselves out of referring patients for the examinations, even though overtly they denied withholding patients from involvement.

The Setting

In our opinion, the setting at the Neuropsychiatric Institute (NPI) ideally met the logistical requirements of the Board examinations. All the examinations took place in one building (in fact, mostly on one floor). This obviated the necessity of traveling be-

tween institutions for various parts of the examination as is sometimes necessary when the Boards are held in other cities. Also, ample numbers of NPI personnel were available to ensure a smoothly functioning operation. As for the patients, every effort was made to make the examinees and examiners comfortable.

In addition, the Neuropsychiatric Institute is a modern building, located in pleasant surroundings with ample, excellent lodgings available in the vicinity to the examinees and examiners. The weather during the examinations was mild and clear, no doubt affording a pleasant contrast for those candidates coming from colder climates. This salubrious setting, by positively affecting the examiners and examinees, may have also contributed to the general acceptance of the examinations by the patients.

Conclusions

This pilot study was intended to assay the effect on patients who, in participating in the examinations of the American Board of Psychiatry and Neurology, served as subjects to be examined by prospective diplomates. Special attention was paid to the attitudes of trainees who referred patients for examina-

tion, since these attitudes related to patient response.

No serious consequences were noted by either patients or therapists with respect to the patients' welfare or therapy as a result of participation in the Board examinations. On the contrary, the patients tended to view the experience as a slightly positive one, though this trend was not statistically significant. There was evidence that trainees generally tended to view the participation of their patients in a less positive light with respect to how the exams influenced their patients and the therapeutic process. In other words, the trainees may have exhibited some overconcern and possibly overprotectiveness toward their patients vis-à-vis the examination experience.

Further study, employing more rigorous observations in different examination settings, is needed to more fully explore this area since: 1) the patients are being used for purposes other than those intended to directly benefit them, and thus their welfare must be considered, and 2) the results of examinations may be significantly affected by factors other than the qualifications of the examinee (e.g., resident attitude, patient attitude, and setting). We hope this initial, exploratory study will stimulate further interest in solving such problems.

Acute Brain Syndrome Associated with Lithium Therapy

BY PETER L. AGULNIK, M.D., D.P.M., ALBERTO DIMASCIO, PH.D.,
AND PATRICIA MOORE, R.N.

Three patients who were treated with lithium displayed symptoms resembling those of organic brain syndrome when their blood lithium levels were low. All patients' lithium levels were slow to rise. When lithium was stopped, the patients' blood levels began to rise and then fell, at which time their symptoms remitted. The authors postulate that this lithium toxicity may possibly be due to tissue lithium levels.

LITHIUM THERAPY may produce inconvenient side effects such as gastrointestinal upsets, tremor, polyuria, etc., when there are low levels of lithium in the blood, or it may produce severe toxic symptoms when serum levels rise above 2 mEq./liter. The development of confusional states and lapses into coma, which have been noted in the more severe form of lithium poisoning (1), are relevant here since our purpose is to present three case histories in which signs suggestive of an early organic brain syndrome occurred when blood lithium levels were low.

The three patients, who had been admitted to Boston State Hospital, were included in a controlled clinical trial of lithium carbonate for treatment of manic and schizo-affective disorders after diagnostic agreement by two independent raters and full physical and laboratory examinations. Laboratory determinations of blood lithium levels, elec-

trolytes, and white blood cell counts were performed three times weekly. The accuracy of the lithium level assays were periodically checked by an independent laboratory.

Case Reports

Case 1. H.M., a 29-year-old man, was admitted to the hospital in a state of acute psychotic excitement, with a one-month history of increasing activity and verbosity associated with feelings of excitement and elation. He was diagnosed as being in the manic phase of a manic-depressive psychosis. His history revealed that this was his fourth hospitalization since the age of 23, twice with a diagnosis of manic-depressive psychosis, manic phase, and once with a diagnosis of schizophrenia.

He was given lithium carbonate, starting with .75 gm. a day and increasing to 2.5 gm. by the sixth day. His blood lithium level had risen to only 0.9 mEq./liter by the end of the first week. There was no clinical change during this period. The lithium dosage was reduced after the ninth day to 2.0 gm. daily because of side effects (anorexia, diarrhea, and tremor). Clinically the patient's thought processes became increasingly incoherent, and the content more bizarre and filled with archaic images. His motor activity became markedly reduced, with periodic hypersomnolence. He was distractable, withdrawn, and showed progressive degradation of personal habits. He developed visual illusions and became totally disoriented as to time, place, and person. Despite the similarity of this illness to an acute delirium with occasional lucid intervals, the patient had no clouding of consciousness. The highest level of plasma lithium recorded during this week was 1.15 mEq./liter.

The lithium dosage was maintained at 2.0 gm. daily until the 19th day. The highest plasma lithium level obtained overall was 1.65 mEq./liter. Since the patient was becoming obviously paranoid and was having auditory and visual hallucinations, the lithium was reduced on day 20 to .75 gm. daily. He was also given one 200 mg. dose of chlorpromazine, but this caused postural hyp-

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potension and was stopped. On the 22nd day the patient's plasma lithium level was 1.35 mEq./liter. On the 24th day he showed a dramatic clinical improvement. He became completely coherent and displayed no evidence of disorientation. His blood lithium level on day 26 was 0.5 mEq./liter. Thus, this patient's blood lithium levels were relatively slow to rise, and four days after reducing lithium intake, along with falling blood lithium levels, his confusional symptoms cleared dramatically.

Case 2. J.P., a 45-year-old man, had had nine recurrent manic-depressive episodes that required hospitalization since the age of 22. Seven of these were classic manic episodes and two were depressive episodes. At no time had he hallucinated or shown evidence of disturbed thought processes of a schizophrenic type. Two months prior to admission he developed a typical hypomanic illness that culminated in rehospitalization.

Treatment with lithium carbonate was initiated and the dosage was quickly increased to 2.5 gm. daily during the first week. The highest blood lithium level obtained during this time was 0.8 mEq./liter. Clinically, his social conduct deteriorated, particularly with respect to irritability and hostility. Pressure of speech was more marked and thought association looser. The overall clinical picture was that of a manic illness which had become progressively more severe and disintegrated. By the eighth day the patient was showing rapidly increasing evidence of disorientation. There was no clouding of consciousness.

Since the patient's blood lithium level failed to rise above 1.25 mEq./liter, the lithium dosage was increased on the 13th day to 3.0 gm. daily. Further deterioration was now noted. The patient was confused, had poor powers of comprehension, and had virtually no capacity to look after himself. From being grossly overactive, he became retarded. On the 17th day, when his blood lithium level had risen to 1.5 mEq./liter, his clinical picture was more in keeping with that of a toxic delirium, with marked tremor, ataxic gait, and muscle fasciculation. He was anorexic and mildly dehydrated. On day 18, the lithium dosage was reduced from 3.0 gm. to 2.25 gm., but the patient's blood lithium levels continued to rise to a peak of 1.9 mEq./liter on day 19. Medication was cut to .75 gm. on day 19 and terminated the next day. On day 21, 48 hours after stopping lithium, a dose of .75 gm. daily was reinstituted with 4 mg. of haloperidol. Within 48 hours, at a blood lithium level of .9 mEq./liter, the patient's toxic features disappeared and there was no evidence of active psychosis. He stayed asymptomatic for a week, the haloperidol was withdrawn, and he has been maintained on a low dose of lithium.

Case 3. L.B., a 47-year-old woman, was ad-

mitted to the hospital with an acute schizoaffective psychosis. A mild manic episode diagnosed two years previously, followed by a short depressive reaction, had been her only previous psychiatric illness although she had a somewhat schizoid personality but no previous report of confusion. Her illness had begun a few days prior to admission when she started to become overactive, verbose, grandiose, and elated, and also suspicious, irritable, and argumentative. On admission she demonstrated mild thought disorder and ideas of influence but was not hallucinating. Treatment with lithium carbonate started with a dosage of .75 gm. daily, which was increased to 2.0 gm. daily by the third day. The dosage was maintained until the eighth day when, because of her deteriorating condition, it was reduced and stopped over the next two days.

Her blood lithium level had been 1.5 mEq./liter on day eight, reached its highest point—1.9 mEq./liter—on day 11, and was 0.7 mEq./liter on day 13, three days after all lithium was stopped.

Clinically, disorientation was noted within three days from the time lithium was begun. Her thought processes became bizarre and disconnected and she became progressively more disorganized, hostile, and unable to care for herself. By day eight she was withdrawn, disoriented as to time and place, showed memory impairment, and had both auditory and visual hallucinations. Blood electrolytes and urea remained normal throughout.

On the tenth day, chlorpromazine was administered and within the next two to three days the patient showed a marked improvement.

Discussion

All three patients described here developed signs of a toxic confusional psychosis at blood lithium levels considerably lower than 2.0 mEq./liter. All had been given a relatively high lithium dosage but their blood levels failed to rise as rapidly as other reports would have predicted. This failure, accompanied by the lack of clinical improvement, led to prescribing progressively higher doses and, paradoxically, to further clinical deterioration. On reducing and stopping lithium the blood levels continued to rise for a day or two before starting to fall in two patients. All three patients had a dramatic remission in symptoms when their blood lithium levels started to fall.

In these patients the blood lithium level did not seem to accurately reflect the total level of lithium in the body, which, it would be postulated, is differentially retained in the

tissues against a concentration gradient.

The patients described augment a similar report by Johnson and associates (2) and one case report by Mayfield and Brown (3), who also noted toxic confusional changes in a group of schizo-affective patients whose blood levels ranged from 1.16 to 1.97 mEq./liter. Of the three cases presented here, one was clearly diagnosed as schizo-affective. Case 2 was more typical of a manic-depressive psychosis, but atypical features were present.

While some may argue that these were not cases of confusional psychosis due to lithium but rather to other situational factors or even to the natural progression from manic excitement to manic delirium, we do not think so. The rapid change in the course of their illness when lithium was reduced would argue against these possibilities. Other drugs were also prescribed, but the dosages were small and the dramatic and sudden remission in symptoms would not have been predicted from the usual clinical experience with such amounts.

The metabolism of lithium in these patients seems different from that found in either manic or normal individuals. The capacity of manic patients to tolerate and retain high doses of lithium until a remission in manic symptoms occurs was noted by Trautner and associates (4) and confirmed by Greenspan and associates (5). It cannot be assumed, however, that lithium was an ineffective agent in our study, since the symptoms of all three patients remitted in a manner described in the literature on lithium. That this sudden improvement occurred a couple of days after stopping lithium, when the blood lithium levels, but not necessarily the tissue lithium levels, were relatively low, is of considerable theoretical interest.

Greenspan and associates (5) concluded that acutely manic patients store lithium ions in the intracellular water of certain tissues or in an extracellular space other than plasma.

Assuming that the patients reported here did not excrete lithium excessively, one explanation of the findings would be that the low blood lithium levels reflected an avidity of such nonplasma compartments for the lithium ion against the concentration gradient, which is even steeper than that for manic patients. This would then produce tissue lithium levels that could result in the toxic changes described. Laboratory tests for electrolytes, sodium, potassium, and chloride were performed three times weekly. Levels of calcium and magnesium were not determined. Test results for blood-urea nitrogen were within normal limits in the three patients. Our data on serum electrolyte changes during the toxic period do not show an increase in serum levels of sodium resulting from an exchange with lithium ions between plasma compartments and nonplasmatic compartments. In the three patients, serum sodium, potassium, and chloride concentrations stayed within normal limits.

Further studies investigating the distribution and excretion of lithium in such patients are needed. It behooves the clinician to be cautious when blood lithium levels do not rise as expected with increasing lithium doses.

REFERENCES

1. Schou M: Lithium in psychiatric therapy and prophylaxis. *J Psychiat Res* 6:67-95, 1968
2. Johnson G, Gershon S, Hekiman LJ: Controlled evaluation of lithium and chlorpromazine in the treatment of manic states: an interim report. *Compr Psychiat* 9:563-573, 1968
3. Mayfield D, Brown RG: The clinical laboratory and electroencephalographic effects of lithium. *J Psychiat Res* 4:207-219, 1966
4. Trautner EM, Morris R, Noack CH, et al: The excretion and retention of ingested lithium and its effect on the ionic balance of man. *Med J Aust* 2:280-291, 1955
5. Greenspan K, Goodwin F, Bunney WE: Lithium ion retention and distribution patterns during acute mania and normothymia. *Arch Gen Psychiat* 19:664-673, 1968

Two-Way Television: Helping the Medical Center Reach Out

BY CECIL L. WITTON, M.D., AND REBA BENSCHOTER, M.S.

Since 1959, the University of Nebraska Medical Center has been using two-way closed-circuit television for medical treatment and education, largely in psychiatry. Television has been used to link the medical center with hospitals in remote rural areas, as well as to assist in educational programs within the university complex. Electronic communication has been valuable in extending education and services.

TWO-WAY TELEVISION is not a new concept. It goes back in time beyond the current decade, in fact beyond this generation, making it nearly impossible to guess who first envisioned the tremendous potential of this tool and the promise it holds for medical education and practice.

The Bell System has promised that sometime in the 1970s the ultimate in two-way picture and sound communication will be available with the wide distribution of phonovision. It is not difficult to imagine the many conveniences in health care and education that will result.

While waiting for phonovision or its equal, the University of Nebraska Medical Center has been experimenting for 12 years with the potential of two-way audio and video transmission in medical treatment and education (1). In 1959, the Nebraska Psychiatric Institute (NPI), which is the department of psychiatry for the medical school, first used two-way television to transmit demonstrations with neurological patients and case information to freshman medical students seated in laboratories across the campus. The return television picture and accompanying sound

made it possible for the instructor at NPI to relate to the students and to watch their participation and reactions.

In 1961, a grant-supported pilot study was undertaken to determine the value of two-way television in psychiatric treatment (2). Patients in group psychotherapy were seated in one room and the therapist in another. In the patients' group the therapist was present on a TV monitor. In turn, a television picture of the group was transmitted to the therapist. During six sessions conducted with each of four groups, the patients and the therapist saw and heard each other only by closed-circuit television. Four other control groups met for six sessions each using conventional psychotherapy techniques, i.e., the therapist was actually seated in the group. Analysis of rating scales of patients and of therapists showed that the choice of therapist and the selection of group members influenced the effectiveness of therapy more than the use of the TV technique. In other words, the presence of television was neither a problem nor an asset.

After this project, the same technique was used in individual therapy. A patient was treated for nearly a year, seeing his therapist only on television. Again the use of TV did not affect either the establishment of rapport between the patient and the psychiatrist or the attitude of either toward the therapy situation.

Across 112 Miles

In 1964, the National Institute of Mental Health funded an application that permitted the installation and operation for six years of a two-way closed-circuit television system between NPI at the University of Nebraska Medical Center and the Norfolk State Mental Hospital, 112 miles away. The Norfolk hospital has had many problems common to

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such isolated health facilities: difficulties in recruiting and retaining trained staff, in providing in-service training opportunities, and in taking advantage of consultation services available only in a large medical center (3-5).

The two-way television system provided face-to-face electronic communication between the Omaha and Norfolk institutions 24 hours a day every day. (The actual scheduled hours of use averaged approximately 45-50 hours a week during the six years of operation.) State hospital personnel or patients could see and hear a closed-circuit television transmission from NPI, and at the same time participants at NPI could see and hear them.

Transmission facilities and services were provided by the Northwestern Bell Telephone Company. In establishing a system of this type in a small community where there were no electronics distributors or technicians, it was important to select durable, portable equipment that was simple to operate. It was also necessary to designate one person in the institution to be responsible for the care and operation of the equipment. The state hospital EEG technician also became the television technician and was given limited training. Knowing that someone maintained the TV connection as a constantly available tool for saving work and time led the staff members of both institutions to accept the system.

The television picture and sound could originate from any of several locations at each station. A direct telephone line was available for scheduling the system and for use by the technicians during programs. A Xerox telecopier was installed at each location to transmit and receive printed matter such as patient charts, reports, and class materials.

Goals

When this two-way television project was proposed, the NPI and state hospital staff members set four specific goals: 1) improved education and training opportunities for state hospital staff at all levels, with corresponding educational benefits to the NPI staff; 2) use of state hospital resources in the teaching programs of NPI; 3) improved state hospital patient services; and 4) increased collaborative research activity.

To improve education and training many

activities were initiated. Joint TV conferences were held weekly by the nursing services of NPI and the state hospital. The nursing staff members discussed common problems and participated in in-service educational programs. Staff members of the social service, psychology, and vocational rehabilitation departments held similar meetings.

Specialized courses for such groups as the clergy, general practitioners, social group work interns, and graduate nurses were telecast (6). The county medical society was another group reached by the medical center staff using the TV system.

A joint grand rounds was shared each week by the professional staff members and students of both institutions. Responsibility for content alternated between NPI and the Norfolk State Hospital. The presentations of NPI's series of distinguished visiting lecturers were transmitted by two-way television to the state hospital from the NPI auditorium.

Patient Services

Improvement in services to state hospital patients was accomplished in several ways. For example, since the state hospital did not have a staff neurologist, an NPI neurologist provided his services each week via TV. Early studies indicated that it was possible to observe reasonably detailed neurological examinations on television. EEGs could also be read quite easily with inexpensive equipment.

Consultation was also given on request in psychosomatic medicine, child psychiatry, and speech evaluation. These practices in effect increased the staff available to the isolated state hospital by making the professional staff of NPI readily available.

Because of the acute shortage of psychiatrists at Norfolk, ward administration proved to be one of the most effective uses of the system (1, 4, 7, 8). Beginning in January 1965, on a 35-bed security ward for women, an Omaha psychiatrist used two-way television to talk and work with state hospital ward personnel and patients for 30 minutes each day. His goals were to achieve better patient management by adequate medication and to change the attitudes of the ward personnel, who thought of themselves as custodians rather than as therapists. The long-distance

ward administration brought a rapid change in this situation.

As the program progressed, three NPI psychiatrists administered ten wards at Norfolk. The total inpatient population at the state hospital dropped from 900-plus in 1965 to 476 in December 1968. The state hospital administration felt that the treatment programs set up by the TV psychiatrists were certainly contributing factors in this decline (3, 9).

Patient services were also improved by using the system about eight hours each week to enable patients to see and talk with their relatives in the Omaha area. Distance, inconvenient public transportation, expense, or health and family problems frequently prevented patients' families from traveling to Norfolk, so the TV visits were important in helping the hospitalized patient remain an active member of the family.

Progress was also made toward the goal of facilitating and encouraging research. Staff members at both institutions used the two-way system to discuss their investigations, to share advice on research design, and to present research findings at seminars and staff meetings.

The Present Network

A new medical television system in Nebraska currently connects three Veterans Administration hospitals and the University of Nebraska Medical Center. The VA hospitals are in Omaha, Lincoln (55 miles from Omaha), and Grand Island (150 miles from Omaha). The switching center of the network is located at the Omaha facility. Studios at the medical center are located at NPI and at University Hospital. The system was formally established in 1968 through an agreement between the university and the VA to exchange medical information.

During 1970 this system was in use for 1,267 hours. Approximately 68 percent of the time was spent in educational activities, 25 percent in patient care functions, and seven percent for miscellaneous purposes.

In patient care, consultations with specialists in Omaha have expanded the services of VA hospitals. Many of the hospital departments use the television network for regular conferences to discuss common problems and exchange case information. The VA psychi-

atric services use the electronic connection with NPI for a variety of treatment and training activities.

Educational uses of the system have included psychiatric orientation of VA staff members and trainees through formal lectures and supervisory meetings with specialists, staff members, residents, medical students, and other trainees at NPI. In non-psychiatric areas, in-service training courses for nurses have been held over television. Monthly two-way TV training conferences for ambulance drivers and other emergency care personnel drew wide participation from communities surrounding the hospitals.

Pros and Cons

The greatest advantage of the two-way television systems is obvious: They help accomplish goals. Other advantages are found in shrinking miles, in increasing the number of available staff members at participating hospitals, and in improving interpersonal and interinstitutional relations.

Of course, there are disadvantages. Some staff members at all of the institutions were at first hesitant to participate in the TV programs. In most instances a single use of the system removed this hesitation (1). In the Norfolk project, patients and relatives were most receptive to the electronic communication. Records of patient-relative visits show that only one patient, a geriatric case, found the television upsetting.

There are still technical problems to be overcome if two-way television is to be an undemanding, unobtrusive communications tool. Sound pick-up and camera operation with large groups are more complicated and require more skill from the technician than small group or individual presentations. In all person-to-person uses the equipment was unattended.

Costs must also be considered a drawback. Transmission charges between Omaha and Norfolk were approximately \$48,000 a year. Had the system been used during every available hour, the service would have cost approximately \$5.50 an hour. Obviously, it is nearly impossible to use such a facility on a 24-hour basis. Specialized equipment could have been added to make possible the transmission of many kinds of information in the idle hours, but in this case the added costs

were prohibitive and the demands limited.

Another possibility for lessening the financial burden would have been to share the facilities with other institutions between Omaha and Norfolk. However, this might have led to a "party-line" situation, with difficulties in scheduling and a lack of privacy.

There is no doubt that biomedical uses of common carrier television services must increase despite costs. If this occurs, an adequate network of transmission facilities will blanket the country. This should lower common carrier rates. It is also probable that other communications firms will see fit to invest their capital in such systems.

The possibility of the University Medical Center's building and operating its own microwave facility has often been discussed. In 1963, when the Norfolk long-distance project was planned, this was neither economically nor technically advantageous. Microwave engineers were not plentiful in Nebraska at that time and are still in short supply. A medical network requires a reliable system.

Conclusions

Two-way television has considerable potential for extending health education and health services beyond the confines of the medical center to local and distant institutions, clinics or community hospitals, and perhaps eventually to the physician's office,

the high school counselor, or the small-town PTA meeting. Like all communications tools, it will be effective in direct proportion to the amount of careful planning put into selecting the best system, determining appropriate uses, and encouraging interest and participation, both within the medical center and with individuals, groups, or institutions beyond.

REFERENCES

1. Benschoter RA: Multi-purpose television. *Ann NY Acad Sci* 142:471-478, 1967
2. Wittson CL, Affleck DC, Johnson V: Two-way television in group therapy. *Mental Hospitals* 2:22-23, 1961
3. Benschoter RA, Wittson CL, Ingham CG: Teaching and consultation by television. *Mental Hospitals* 16:99-100, 1965
4. Link brings psychiatric assistance to wards of remote state hospital. *Psychiatric Progress*, Dec 1965, p 5
5. Wittson CL: Nebraska initiates cross-country TV-psychiatry. *Educational Screen and Audiovisual Guide* 44:22-23, 39, 45, 1965
6. Benschoter RA, Garetz C, Smith P: The use of closed-circuit TV and videotape in the training of social group workers. *Social Work Education Reporter*, July 15, 1967, pp 18-19
7. Benschoter RA: Progress Report on Two-Way CCTV. Omaha, Nebraska Psychiatric Institute, 1965 (processed)
8. Menolascino F, Osborne RG: Psychiatric television consultation of the mentally retarded. *Amer J Psychiat* 127:157-162, 1970
9. Hedman LL, Mansfield E: Hospital to hospital via TV. *Amer J Nurs* 67:808-810, 1967

Psychogenic Water Intoxication: A Case Report

BY MICHAEL W. DEVEREAUX, M.D., AND RUTH A. MCCORMICK, M.D.

The authors describe a case of a 41-year-old schizophrenic woman who was treated for water intoxication due to compulsive water drinking. The patient presented in a coma, with convulsions and evidence of congestive heart failure. The authors describe her treatment in detail and believe that she appeared to have the most severe case of water intoxication of any reported thus far.

PSYCHOGENIC water intoxication is an uncommon syndrome, but it is not unknown in the medical literature (1-4). The purpose of this article is to present an extreme example of the syndrome and to briefly review the literature.

Case Report

B.L. is a 41-year-old Mexican-American woman who presented to the Neurology Admitting Service of the Los Angeles County-University of Southern California Medical Center in the throes of a generalized grand mal convulsion. No immediate history was available since her family could not be reached. Her hospital chart revealed a past history of paranoid schizophrenia, chronic alcoholism, and a seizure disorder thought to be secondary to ethanol abuse. The patient was given 100 mg. of diphenylhydantoin and 100 mg. of phenobarbital, intramuscularly. Physical examination in the immediate postictal period revealed that she was comatose with no signs of head trauma or focal neurologic deficits. An equivocal Babinski's sign was present bilaterally. A general physical examination was normal except for scattered rhonchi. A blood sample was taken for routine laboratory determinations and the patient was observed.

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Several hours after the seizures, the patient could still not be roused. A lumbar puncture revealed clear cerebrospinal fluid, with an opening pressure of 250 mm.; an echoencephalogram was normal. The patient began demonstrating decorticate posture¹ shortly after these two tests were performed. The blood chemistry tests taken on admission showed the following results: serum sodium—less than 100 mEq./liter, blood urea nitrogen—2 mg./100 cc., potassium—3.4 mEq./liter, glucose—126 mg./100 cc., and bicarbonate²—21 mEq./liter. A portable chest X ray showed perihilar congestion compatible with pulmonary edema. The patient was intubated, and intermittent positive pressure breathing was started. An indwelling catheter yielded only a small amount of urine, with a specific gravity of 1.000. A venous cutdown was performed and the central venous pressure was 15 cm. of water.

The patient was given 25 gm. of mannitol over a 20-minute period. She was also given 250 mg. of diphenylhydantoin and 100 mg. of hydrocortisone, intramuscularly. Following diuresis and a drop in the central venous pressure, she was given 250 cc. of three-percent hypertonic saline solution over a four-hour period. This was followed by a second dose of 250 cc. over a 20-hour period. At this time her serum sodium level was 121 mEq./liter. When this treatment was instigated, the serum osmolality was 207 mOsm./kg. and the urine osmolality was 0 mOsm./kg. This latter value was falsely low due to contamination by a bladder irrigant.

The family was finally contacted 24 hours after the patient's admission. The patient's husband stated that he told her three weeks before her admission to stop drinking alcohol or he would leave her. She responded by stopping her consumption of alcohol, but shortly thereafter began drinking large quantities of water. The husband observed that she rarely left the kitchen during this period.

¹ Decorticate posturing consists of flexion of the arm, wrist, and fingers with adduction in the upper extremity, and extension, internal rotation, and plantar flexion in the lower extremity. In this patient, it suggests dysfunction of the cortical spinal tracts bilaterally above the brain stem. This posturing can be seen with destructive lesions of the internal capsule as well as in metabolic disorders.

² Bicarbonate refers to the level of carbon dioxide in the blood.

She had no history of previous episodes of excessive water intake.

The patient remained comatose for 36 hours following admission and was decorticate most of the time. Upon awakening, she was noted to be grossly psychotic and was started on large doses of chlorpromazine. The neurologic examination was normal. Controlling her intake of water proved to be a problem: on numerous occasions she was found drinking from other patients' water containers and from flower vases.

An electroencephalogram, a brain scan, and a pneumoencephalogram were normal. An angiogram performed during a previous admission had been normal. The patient was later discharged to a psychiatric institution.

Discussion

The term "water intoxication" was made popular by Roundtree (5), who used it to describe the symptoms of increased neuroexcitability produced by the sudden dilution of body solutes through the excessive intake of water. The causes of water intoxication are several. Most often it occurs as a result of overzealous postoperative intravenous hypertonic fluid therapy, usually in the young and in the aged (1, 6). It has also been reported in association with patient-induced enemas and proctoclysis (7-10).

Still another cause, compulsive water drinking, has been described in the medical literature (1-4, 7). It has been defined by Barlow and DeWardener (2) as excessive consumption of water due to a psychological disturbance. Whatever the etiology of the intoxication, the symptoms are virtually the same. They are primarily neurological and consist of headache, reduction in awareness and responsiveness, tremulousness, coma, and convulsions (10). Coma and convulsions did not occur in any of the cases reviewed when the sodium level was greater than 123 mEq./liter.

The pathophysiology of the symptomatology is cerebral edema (9, 11, 12). The hypertonicity of the extracellular fluid produced by increased water intake results in an osmotic gradient that drives water intracellularly. This is obviously not confined to brain tissue and occurs in other major organs. Baskin and Keith (13) pointed out that the absolute concentration of serum sodium bears no relation to the production of neurologic symptoms; rather, the rate of change in solute concen-

tration appears to be the critical factor.

The case report presented here differs from other reported cases of psychogenic water intoxication in one respect: the woman's clinical condition was more severe and her laboratory findings were more deranged than in any of the cases reviewed. Not only was she in a coma, with convulsions and decorticate posturing, but she also showed evidence of congestive heart failure (i.e., elevated central venous pressure and pulmonary edema).

Patients presenting with less severe clinical and laboratory findings can be treated conservatively, with fluid restriction as the cornerstone of therapy. If seizures occur, anticonvulsants should be used. In severe cases therapy must be more aggressive. Diuretics are important both to produce diuresis and to reduce cerebral edema. Hypertonic saline solutions can also be administered. When these solutions are given, great care must be exercised and monitoring of central venous pressure is essential. If the patient is in congestive heart failure, the use of hypertonic saline solution is, of course, extremely hazardous. Before hypertonic saline was started in this patient, diuretics were given, good urine output was established, and the patient was intubated and receiving ventilatory assistance.

Summary

A 41-year-old schizophrenic woman was recently treated at Los Angeles County-University of Southern California Medical Center for water intoxication due to compulsive water drinking. She presented in a coma with grand mal seizures and evidence of congestive heart failure. Her history, obtained later, revealed a two-week course of compulsive water drinking prior to admission. Therapy consisted of diuretics, anticonvulsants, intravenous hypertonic saline solution, and ventilatory assistance. Central venous pressure was also monitored. The patient's recovery was complete, and she was later transferred to a psychiatric hospital.

A brief review of the literature showed compulsive water drinking to be an uncommon but not an unknown cause of water intoxication. This case appears to be the most severe of any reported to date. The pathophysiology of the symptomatology of the central nervous system is cerebral edema.

REFERENCES

1. Bewley TH: Acute water-intoxication from compulsive water-drinking. *Brit Med J* 2:864, 1964
2. Barlow ED, DeWardener HE: Compulsive water drinking. *Quart J Med* 28:235-258, 1959
3. Murphy FJ, Zelman S: Water metabolism and the psychiatric patient. *J Urol* 92:60-63, 1964
4. Resnick ME, Patterson C: Coma and convulsions due to compulsive water drinking. *Neurology* 19:1125-1126, 1969
5. Roundtree LG: Water intoxication. *Arch Intern Med* 32:157-174, 1923
6. Crawford JD, Dodge PR: Complications of fluid therapy in neurologic disease: water intoxication and hypertonic dehydration. *Pediatr Clin N Amer* 11:1029-1052, 1964
7. Staunton SB, Van Allen MW: Water intoxication. *J Iowa Med Soc* 57:665-667, 1967
8. Swanson AG, Iseri OA: Acute encephalopathy due to water intoxication. *New Eng J Med* 258:831-834, 1958
9. Helwig FG, Schatz CB, Currey DE: Water intoxication. *JAMA* 104:1569-1575, 1935
10. Wynn V, Rob CG: Water intoxication: differential diagnosis of the hypotonic syndromes. *Lancet* 1:587-594, 1954
11. Dodge PR, Crawford JD, Probst JH: Studies in experimental water intoxication. *Arch Neurol* 5:513-529, 1960
12. Wasterlain CG, Posner JB: Cerebral edema in water intoxication, I: clinical and chemical observations. *Arch Neurol* 19:71-78, 1968
13. Baskin JL, Keith HM: Water metabolism in water intoxication: review of basic concepts. *Amer J Dis Child* 83:618-627, 1952

LETTERS TO THE EDITOR

Reaching Black Professionals

SIR: I should like to respond to Dr. Viola Bernard's article entitled "Interracial Practice in the Midst of Change" (February 1972 issue). Dr. Bernard, in my opinion, has perceptively clarified the black man's anger toward the white majority and has not merely interpreted the situation as an overemphasis of the racial question by the analyst (1).

My second comment concerns Dr. Bernard's discussion of "institutionalized racism." In her article she states that "... because of institutionalized racism their number [black psychiatrists] is still so disproportionately small that the interactions among black and white psychiatrists in all of these fields is insufficient. . . ." I happen to follow a major black publication entitled *The Journal of the National Medical Association*. From reading Dr. Bernard's article, I feel that she would like to increase the number of interactions between black and white mental health professionals. To do this I believe it would be more productive to publish an article with this theme not only in a journal read predominantly by white professionals, but also in a journal that receives the enthusiastic support of black professionals.

The reference is:

1. Bernard VW: Psychoanalysis and members of minority groups. *J Amer Psychoanal Ass* 1:256-267, 1953

L. H. LIPSIOUS, M.D.
Atlanta, Ga.

Dr. Bernard Replies

SIR: I appreciate the comments of Dr. Lipsius regarding my article. His suggestion that it would be more productive to publish such an article in the *Journal of the National Medical Association* warrants, I believe, a two-fold response, i.e., a more specific and a more general one.

Specifically, with regard to this particular article, the background of its publication in *The*

American Journal of Psychiatry seems pertinent. Dr. Hugh Butts, a colleague who is a black psychoanalyst, invited me, in his capacity as a member of the APA Program Committee, to participate in an interracial panel discussion on racism to be held as a joint session of the American Psychoanalytic and American Psychiatric Associations at the annual meeting of the American Psychiatric Association in Washington, D.C., May 1971. In accepting I was particularly pleased that this panel was itself an instance of professional interaction among black and white psychiatrists, both among the panelists and among those attending the session, a number of whom participated in the discussion. All papers that are presented at APA annual meetings become the property of the Association and cannot be published in a publication other than the *Journal* until and unless the author is notified that his or her paper is rejected or is released for publication elsewhere. I was pleased that my manuscript was accepted by the *Journal* because it has the widest circulation among psychiatrists, black as well as white, and so its publication also served as a means of interracial interaction.

On the more general question that Dr. Lipsius mentions, I am not sure that it would be "more productive" to have published my article in the *Journal of the National Medical Association*—were that journal to accept it—since I believe *The American Journal of Psychiatry* does have an interracial readership and, in contrast to NMA's journal, concerns the specialty of psychiatrists, for whom this paper was intended, rather than the whole field of medicine.

On the other hand, I fully agree with Dr. Lipsius that conveying my paper's theme through the *Journal of the National Medical Association*, as well as *The American Journal of Psychiatry* would further serve the purpose of increased intercommunication between black and white professionals. It would be a welcome by-product of my paper if this correspondence might stimulate the writing of such a paper and its acceptance by the *Journal of the National Medical Association*.

VIOLA W. BERNARD, M.D.
New York, N.Y.

Letters to the Editor are welcomed and will be published, if found suitable, as space permits. Please submit two copies (typewritten, double-spaced), the length, if possible, not to exceed 500 words. Letters will be subject to the usual editing.

Goiter in Psychiatric Patients

SIR: Drs. Ronald Fieve and Stanley Platman in their article "Follow-Up Studies of Lithium and Thyroid Function in Manic-Depressive Illness" (April 1969 issue) reported that in a group of 13 manic-depressives who had been receiving imipramine colorscans revealed goiters in four patients and thyroid nodules in another three. None of the goiters was "clearly palpable."

In a group of 29 patients with recurrent affective disorders studied at St. Patrick's Hospital in Dublin, Ireland, and described elsewhere (1), four had clinically observable goiters and another two had had thyroidectomies. The group had had a mean episode frequency of 2.55 new episodes of affective disorders a year for at least four years prior to examination.

The high incidence of goiter in Fieve and Platman's group and in the St. Patrick's Hospital group stimulated us to make a survey of goiters in psychiatric patients admitted to St. Patrick's Hospital.

Two hundred patients admitted consecutively to the hospital were examined for goiter by inspection and palpation. Among these, eight (four percent) had goiters. Two of the goiters were nodular; one of them was in a patient who had had a thyroidectomy. In the remaining six patients, the goiter was visible but not pronounced. Of the 118 male patients, one (0.8 percent) had goiter; of the 82 female patients, seven (8.5 percent) had goiter. All patients were clinically euthyroid.

Of the 200 patients, 106 suffered from manic-depressive-type disorders (*International Classification of Diseases* categories 296.0, 296.1, 296.2, and 296.3) (2); five (4.7 percent) of the goiters were found in this group. The remaining three (3.2 percent) goiters were found in the 94 patients who suffered from other psychiatric disorders. The slightly higher incidence of goiter in the manic-depressive-type patients is explained by a relatively higher proportion of female patients in the manic-depressive group (55 men and 51 women), as compared to the total group (118 men and 82 women).

The overall incidence of goiter in the 200 patients is not greater than that noted in Irish populations in the past (3). However, data on contemporary adult Irish populations are not available.

The present study does not show the high rate of goiter previously found in a St. Patrick's Hospital group of 29 patients who had recurrent affective disorders. Possibly this earlier high rate was due to chance, or alternatively, the discrepancy between the two observations may be due to the fact that the first group consisted of patients with recurrent affective disorders showing an unusually high episode frequency. The episode frequency of Fieve and Platman's group of manic-depressives who had a high rate of goiter is not given. However, as

they pointed out, the high rate that they found may be explained by their use of a sensitive method of examination, the colorscan.

It is suggested that further surveys of goiters in patients with recurrent affective disorders with high episode frequencies may be worthwhile.

The references are:

1. Melia PI: Prophylactic lithium: a double-blind trial in recurrent affective disorders. *Brit J Psychiat* 116:621-624, 1970
2. Registrar General's Advisory Committee on Medical Nomenclature and Statistics: Studies on medical and population subjects, no 22, in *A Glossary of Mental Disorders*. London, Her Majesty's Stationary Office, 1968
3. World Health Organization: *Endemic Goiter*. Geneva, WHO, 1960

PATRICK MELIA, M.D.
KENNETH SINANAN, M.D.
FRANK O'DONOGHUE, M.B.
Dublin, Ireland

Schizophrenia and Affective Psychosis: Additional Comments

SIR: The paper "Can Schizophrenia Change to Affective Psychosis?" by Drs. Ziskind, Somerfeld, and Jens (September 1971 issue) contained interesting but hardly original observations. Whereas the authors' careful documentation of a change from schizophrenia to affective psychosis is a new contribution, I was surprised that, in their search of the literature, they overlooked the chapter "Clinical Features of Schizophrenia" in the *Comprehensive Textbook of Psychiatry* (1). In it Dr. Heinz Lehmann writes:

The author's own observations do not confirm the widely accepted psychiatric teaching that a diagnosis of manic-depressive psychosis is often changed later to one of schizophrenia but that the opposite never occurs. During more than two decades at a psychiatric hospital serving the entire English speaking population of the bilingual Canadian province of Quebec, he has many times changed an early diagnosis of schizophrenia made during the first one or two attacks into a diagnosis of manic-depressive psychosis during subsequent psychotic breakdowns (1, p. 644).

The authors might also have credited Dr. George Vaillant's observations of patients followed-up for many years after an original diagnosis of schizophrenia (2).

My experience has been similar to that of Dr. Lehmann. In 14 years of residency training and practice, I have treated three patients whose early

presentation was clearly schizophrenic and whose later breakdowns were typically manic or depressive.

The authors may be interested in a recent article (3) that refers to two French papers (published in 1959 and 1961) describing changes in psychotic symptoms similar to those described in their paper.

The references are:

1. Lehmann HE: Schizophrenia, IV: clinical features, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins Co, 1967, pp 621-649
2. Vaillant GE: The natural history of the remitting schizophrenias. *Amer J Psychiat* 120:367-376, 1963
3. Cerrolaza C, Cleghorn RA: Atypical psychoses. *Canad Psychiat Ass J* 16:507-514, 1971

PAUL C. S. HOAKEN, M.D.
Kingston, Ont., Canada

Drs. Ziskind, Somerfeld, and Jens Reply

SIR: We would like to thank Dr. Hoaken for the additional references. They tend to support a not uncommon occurrence in patients originally diagnosed as schizophrenic and later as manic-depressive. However, our patients presented a unique picture. To begin with, they were essentially all clinically similar. In the first years, each had several schizophrenic episodes requiring hospitalization. Then they all underwent a very gradual change in the direction mentioned, namely, toward affective psychosis. The transition also took place through numerous interval attacks and under the administration of combined somatic therapies, including both anti-schizophrenic drugs such as the phenothiazines, and antidepressants such as the triptylines and lithium.

Space limitations did not permit a fuller picture of the patients' prepsychotic histories than those presented in the article. There were both autistic and predominant affective premonitory symptoms. As to the clinical pictures in the early hospitalizations, closer examination strongly suggests that from the start we were really dealing with combined schizophrenic and affective psychoses. In addition, the patients' family histories revealed that there were other members who had had both types of psychoses.

The hyperacute onset of the early breakdowns pointed to a good prognosis. However, the premonitory symptoms contained elements of mixed prognostic portent.

We believe that psychiatric diagnosis will receive further clarification if attempts are made to single out the combined individual syndromes presented.

The treatment-contingent aspects of the changes we reported need to be reemphasized. This particular illness sequence reflected over the years the

historical development of various therapies. Originally, we had primarily the shock therapies; then came the phenothiazines and the antidepressants. Subsequently lithium entered the picture. There was also the transition from hospital-based therapies to outpatient maintenance therapies, first with therapeutic convulsive treatments and later with medications. The developments are closely related to the sequences in the long history of remitting illness presented by our patients.

EUGENE ZISKIND, M.D.
ESTHER SOMERFELD, M.D.
RUTH JENS, M.D.
Los Angeles, Calif.

Psychiatry as a Medical Specialty

SIR: When I was in medical school, it seemed that colleagues chose to specialize in psychiatry for one of two major reasons: either they were primarily interested in the causes and treatment of disturbed behavior, or they sought to flee as far as possible from the role of physician and framework of medicine.

Depending upon where and when one looks, one finds psychiatry and its practitioners at variable distances from the mainstream of clinical medicine. With distance comes an unfortunate loss of opportunity for psychiatry to share its expertise with allied healing arts—a loss inevitably passed on to patients.

The day of the "complete" physician is past. Knowledge has exploded, and medicine has divided and subdivided like a fertilized ovum. However, for a multicellular organism to remain viable, it must retain all the functions of its simpler ancestors. The old family doctor practiced psychological medicine, knew of the "feedback loops" between psyche and soma, could effectively use the few sedatives available, recognized sudden behavior changes as pathophysiologic heralds, and, perhaps most importantly, saw the patient as a person. Now that the general practitioner has evolved into a team of specialists, the psychiatrist must be included as an integral team member, both as the specialist in behavior and as a humanizer of the system.

But why is there ever a rift between psychiatry and other specialties? If his function is so vital, why is the psychiatrist not always invited in, and, if invited, why does he not always accept? In the first place, as I stated earlier, some psychiatrists find an identification as physician undesirable, whether because of discomfort with the stuff of biology or with the medical model. Second, many physicians are threatened by their own fantasies about psychiatrists or are uncomfortable about anything in their patients that would be "grist" for psychia-

trists' "mills." There is also a third factor, which is more easily remediable. It concerns the relevance of the information we have been transmitting.

The psychiatrist's contact with other physicians begins in medical school and continues in the general hospital. While there are vital areas of knowledge and experience to be communicated, what is taught in the schools and followed through with consultation in the hospitals is often irrelevant to the needs of a nonpsychiatrist. A first-year medical class was informed that their peering through microscopes met a scopophilic need that arose in the oedipal stage. A fourth-year student, inquiring about the evidence for a psychoanalytic theory, is met with an interpretation of *his* need to question authority. A medical house officer is given an elegant psychodynamic formulation of his patient's personality development but finds that his consultant left no clue about how to get the patient to take his medicine.

There are several essential areas that psychiatry must teach in the medical school and reinforce through liaison work in the hospital:

1. *Psychopharmacology.* Drugs falling under this heading are widely misused and are prescribed so frequently that they achieve a multimillion-dollar annual volume. Advertising is frequently misleading (since alcoholism is much more common than schizophrenia, effective antipsychotic agents are often advertised for uses of questionable efficacy). While the general categories of these agents and their indications and precautions are few and simple, the marketplace has given rise to a plethora of minor variants that confuse those who are unfamiliar with the drugs. Every physician can and should be familiar with one or two antipsychotic, mood-affecting, and anti-anxiety agents.

2. *Differential diagnosis of psychiatric syndromes.* The heavy advertising for drugs that purport to treat both anxiety and depression shows the confusion over psychiatric nosology. It is not important for a general physician to distinguish passive-aggressive from passive-dependent or to recognize anal retention syndromes. However, it is critical to know, for example, the signs and symptoms of major depressions (because they are dangerous and can be treated), to inquire as to suicidal thoughts, and to recognize impending psychosis.

3. *Mental status exam.* All too often this simple and vital portion of the physical examination is neglected or uninterpreted. To distinguish a toxic delirium from an acute psychosis is to sharpen one's acumen in an area vital to patient care.

4. *Relating to patients.* Too frequently, doctors do not hear the real message in a patient's communication (e.g., repetitive requests for reassurance masking fear of cancer) or react intuitively to a patient's discomfort without understanding the underlying causes (e.g., hostility belying apprehension). Helping a physician listen to his patients

and deal with his feelings toward them should be the function of the psychiatrist.

5. *Humanizing the practice of medicine.* Here we return to the classic description of the doctor's role: "to cure sometimes, to help often, and to comfort always." When the team approach, particularly in the academic setting, leans to seeing the patient as a disease or as an organ system, the psychiatric member must serve to remind his colleagues of the *raison d'être* of the medical profession and its position in society.

We are at a time in history when our system of health care delivery is being questioned, when traditional roles are being reevaluated, and when medical education is being reoriented. Psychiatry, too, is engaged in this questioning about its role in the field of mental health and in general medicine. I have tried to outline why I feel medicine needs psychiatry as an integral part of its structure. I also feel that our field has much to gain from a close alliance with the other clinical areas. But most important, our obligations to a society that looks to us to mend some of its wounds will best be met by a health care system that functions with a biological integrity.

ALAN J. GELENBERG, M.D.
Boston, Mass.

Establishment of a Psychotherapy Training Department at Tel-Aviv University

SIR: Over the past many years a need has become apparent for an Israeli institute that would provide further training in the theory and practice of psychotherapy. After a lengthy period, the Tel-Aviv University agreed to set up a Department of Psychotherapy within its Division of Continuing Medical Training, which in turn is associated with the medical school of the university. Professor Brüll (head of the Department of Psychiatry) was appointed head of this department. A board of advisors was selected from various university departments such as psychology, behavioral sciences in the medical school, the School of Social Work, and the Ministry of Health and Malben. The institute has two active "friendly" committees: The American group is headed by Dr. Amnon Isacharoff and the South American group is headed by Dr. Leon Grinberg. An education committee, Professor Alberta Szalita, chairman, undertook responsibility for the development of a comprehensive training curriculum in psychotherapy.

The institute accepted its first class of 21 students out of 53 applicants; these students began their studies in the 1971 fall semester.

The first-year program consists of three broad training areas:

1. There is a series of didactic two-hour lectures over the course of the academic year.

2. The students have been divided into three groups for the purpose of continuing case seminars. Each group meets for two hours once a week and follows a program of intensive group supervision and discussion of cases.

3. Each student carries a case load of one or two patients and has selected a supervisor with whom he meets at least once a week for one-hour sessions.

The second-year program, while still to be elaborated, will include intensive training in the areas of family, group, child, adolescent, and adult therapy. The third-year program will be available for specialization in at least one or more of these fields.

Professor Szalita opened the first year with three four-hour meetings that included both didactic and group supervision sessions.

The institute is based on a concept of integrated eclecticism and is thus not tied down to any one specific therapeutic ideology or body of systematically or rigidly applied concepts by which man is to be understood. Rather, it provides a context within which the basic principles of human understanding and help can be explored. The neglect of a fixed ideology does not mean and, one hopes, will not mean that the institute will at any time adopt less rigorous standards in its judgment of training procedures or in the practice of psychotherapy.

Parallel to the training of students, an intensive self-help and retraining program exists for faculty supervisors who, together with the group leaders and invited lecturers, constitute the faculty of the institute.

A philosophy of multidisciplinary selection was adopted, and the student body includes physicians, psychologists, and social workers, all graduates in their profession. This wide range of students provides at least a partial promise of differential pressure on faculty. Because it represents very real areas of interest, this in itself should help call forth faculty response. The wide selection of faculty members from differing schools and professional allegiances also shows promise of greater future cohesion in a presently fragmented professional area.

The challenge of the future remains, but current uncertainty often acts as a spur to future creativity. Lacking tradition, it is the hope of the institute that this creativity will be that which will forward it.

E. H. ROSENBERG, PH.D.
Tel-Aviv, Israel

The Mini-Boards: Their Place in Psychiatric Training

SIR: The March 1972 issue contained two articles by Dr. David E. Raskin: "Mini-Boards: A

Means of Evaluating Psychiatric Residents" and "Psychiatric Training in the 70s—Toward a Shift in Emphasis" (Editor's Notebook). The latter comments I would feel were pertinent to our training status in 1972, but I found the article on the mini-boards to be very disconcerting.

After carefully reading about the mini-boards, I cannot help but feel that Dr. Raskin is saying: "Let's train residents to pass the Boards." I feel very strongly the changing role of psychiatry since I work full-time in a community mental health program. I would fully agree that a psychiatrist must be well trained in dynamics, history, and other areas currently covered by the APA Self-Assessment Program and the Boards, but is this where our training and evaluation should stop?

In psychiatry today, we can no longer separate the medical from the social; we must train psychiatric residents to be qualified leaders in attacking the defects in our environment that play such a large part in the etiology of our current emotional problems. Proper training must involve not only a study of the individual, but also of his social surroundings and of the methods for changing both to be compatible. Our training programs must expand to include such skills as community organization, the assessment of social structure, and, certainly, methods of program evaluation.

The challenge for the educator lies not in training residents for the Boards but in making the training and evaluation process pertinent to today. We must review the goals of psychiatry; when these are established, we can then make our examinations and training meaningfully directed toward creating individuals who can help us achieve our objectives.

J. ALBERT BAXTER, M.D.
Salem, Ore.

Dr. Raskin Replies

SIR: I was not advocating training residents to pass the Boards. If this was the impression my article created, I am grateful to Dr. Baxter for giving me an opportunity to clarify the matter.

The major goal of the mini-board exam is to provide an evaluation of a resident's clinical skills, knowledge, and judgment. The more traditional psychotherapy process-note evaluation is not an adequate tool for this. The content of the mini-boards should include the areas of social and administrative psychiatry. In discussing the evaluation and treatment of an individual or family, social and environmental issues must be carefully considered.

The mini-board examination is a good preparation for the Board format. The mini-board exam, unlike the American Board exam, provides a less formal setting, with immediate feedback about

strengths and problem areas. As the content areas of psychiatry enlarge and change, they should be reflected in the Board exams and in the APA Self-Assessment Program.

I do feel, as I stated in my editorial, that psychiatrists need to begin to define their role as psychiatrists in community mental health centers. Community mental health is an interdisciplinary mental health delivery system, and psychiatrists and all other mental health professionals must decide on role-specific and shared functions.

DAVID E. RASKIN, M.D.
Chicago, Ill.

Psychiatric Training—the Center Must Hold

SIR: Reading the editorial comments of Dr. Morton Reiser ("Training for What?") and of Dr. David Raskin ("Psychiatric Training in the 70s—Toward a Shift in Emphasis") (March 1972 issue) reminded me of the now-popular quote from Yeats: "Things fall apart, the center cannot hold." Like Reiser and Raskin, I feel things must change but need not fall altogether apart. In these times when the center must hold, it helps to say the obvious about what the center of psychiatry is. Here is one brief, obvious, and even banal statement of what the core of training should be.

The trainee in psychiatry needs to learn how to go from clinical observation to clinical inference and back to clinical observation and intervention. This capacity can be developed in relation to different units of observation: the individual, groups, or organization networks. The sequence of observation to inference and back is organized by two kinds of theory—phenomenological and explanatory.

Phenomenological theory informs us of the natural groupings of information as observed by others and, potentially, by ourselves. For example, in the classical medical model, it informs us of what signs and symptoms occur together in characteristic syndromes. There is also a phenomenology of treatment: what syndromes change in what ways in response to what interventions. Explanatory theory informs us of what others have inferred as causes for the phenomenology. Thus, there are motivational, causative, etiological, metaphysical, multifactorial, dynamic, and other kinds of explanatory theory. In the classical medical model these theories divide symptoms and signs into those which are primary (direct responses to the etiological process) and those which are secondary (indirect responses and responses to processes reactive to the etiological factors). Explanatory theories also allow us to devise treatments on a theoretical rather than on an empirical basis and to choose the critical signs or symptoms to observe for treatment effect.

Actually, we use explanatory and phenomenological theories interactively because we believe in feedback between observation and inference. We know that observation is never independent of previous categorical sets, that observation leads to theories, which lead to recategorizations, which lead to revised observations, which lead to categorical revisions, which lead to sharper observation for goodness of fit, and so forth.

Therefore we want to do what David Raskin suggests in his editorial. "We must define a patient population relevant to our backgrounds... that also reflects public health-mental health needs." We should then take this population and approximate it to our students, teachers, and theories. We teachers then must show the students how we observe this population, what phenomenological and explanatory theories guide inference, and how to "sew" back and forth, revising both observation and inference. We must do this so that they, the trainees, learn to make new observations, as well as to consensually validate old ones, and so that they can revise or supplement theories as well as learn them. This is the center we must hold.

In teaching the "stitch" between observation and inference, we would do well to follow the principle of moderation by avoiding the following extremes:

1. Don't inundate the trainees with service requirements, but don't let the trainees retreat from patients (1).
2. Don't use teachers unfamiliar with the observational experience, but don't use teachers who are theoretical nihilists or zealots.
3. Don't provide only one kind of patient experience, but don't scatter the trainee across so many types of treatment experiences that he can make only superficial contact with observation and theory.

If we hold this center we can make progress not only in spite of, but also because of peripheral fluidity.

The reference is:

1. Kubie L: Retreat from patients. *Arch Gen Psychiat* 24:98-100, 1971

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A Correction

Page 1503 of the June 1972 issue of the *Journal* contains an error in the article "Research on Student Activism" by Berns, Bugental, and Berns. Under paragraph 6, the last sentence should read: "A higher frequency (56 percent) of activists came from Jewish families than did activist-sympathizers (ten percent) or conservatives (none)." The authors state that the chi square on this set of data, however, is correct as reported in the article.

BOOK REVIEWS

HEALTH INSURANCE AND PSYCHIATRIC CARE: UTILIZATION AND COST. By *Louis S. Reed, Ph.D., Evelyn S. Myers, and Patricia L. Scheidemandel.* Washington, D.C.: American Psychiatric Association, 1972, 411 pp., \$6.50.

This long-awaited book lives up to its advance billing as "the most comprehensive collection of data on utilization and cost of psychiatric services under private and public health insurance programs ever compiled." It is written in an easy style, using very readable type, and is presented in a logical sequence that makes it easily understandable. Its publication is particularly timely in view of the probable passage of some form of national health insurance in the next two or three years.

Because of the conclusion reached in the book that "insurance coverage for mental health care is feasible," this book should be read and digested by all professionals directly or indirectly connected with the practice of psychiatry, as well as by all professionals associated directly or indirectly with private or public health insurers. The American Psychiatric Association would do well to provide copies to key legislators who are active in the area of national health insurance legislation, as well as to actuaries of the major writers of private health insurance. We can hope that the statistical evidence gleaned from this monumental study of over 40 private and public health insurance plans will silence once and for all those people in insurance, medicine, and government who have contended for so long that "mental health care is not insurable."

To produce a book is something of an accomplishment, but to produce a readable book based on a statistical study is nothing short of a miracle. The authors are to be congratulated for their clarity, from the foreword by Dr. Walter E. Barton, Medical Director of the American Psychiatric Association, to the lengthy appendices. Dr. Barton outlines in his seven-page foreword a brief but complete history of APA's efforts to promote and encourage health insurance coverage for psychiatric care for the purpose—in line with the Association's constitutional mandate—of improving the treatment, rehabilitation, and care of the mentally ill.

The authors have elected to present their information in narrative style in the first half of the book, using some tabular material but reserving the second half (appendices) for detailed descriptions of the various private and public plans, along with a large number of tables documenting utilization and cost under the various coverages.

The six chapters of the narrative half of the book are titled: "The Problem and the Setting," "Coverage Under Private Health Insurance," "Utilization Under Private Insurance," "Utilization by Age, Sex, and Other Characteristics," "Coverage and Utilization Under Public Programs," and "Summary and Conclusions."

Evidence is presented to show that although hospital admissions for mental disorders have increased over the past 25 years, the length of stay and the total number of patients resident in the hospital at any one time have decreased significantly. Those who believe that outpatients continue to see psychiatrists almost indefinitely can note that under CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), which is an essentially open-ended program of coverage in and out of the hospital, the average number of outpatient visits to the psychiatrist per year is between 6.4 and 10.6, with variations by sex and age.

Although the authors do not deny the high cost of individual psychotherapy, we must not lose sight of the fact that one-to-one care by any physician is expensive and yet is quite probably less so for psychiatry than for any other branch of medicine for comparable time periods. In general, their data buttress the stand of APA that mental illness care in insurance plans, private and public should not be discriminated against but rather should be covered like any other illness. Peer review is a necessity in *any* plan, but it should be no different for psychiatry than for any other specialty of medicine.

I urge that this report be utilized by all members of the mental health team everywhere for improving "the treatment, rehabilitation, and care of the mentally ill." Finally, I urge that efforts be made to keep this research team together for further studies along the lines they suggest.

G. BURTON APPLEFORD, M.D.
La Jolla, Calif.

FREUD: LIVING AND DYING. By *Max Schur, M.D.* New York: International Universities Press, 1972, 573 pp., \$20.

This book is the magnum opus of Max Schur, the Viennese internist turned analyst who was Freud's personal physician from 1929 until Freud's death ten years later. In this capacity his main task was, of course, the management of Freud's cancer of the palate, which had appeared in 1923. The ac-

tual surgical treatment was performed by Hans Pichler, a Viennese surgeon whose unfailing strength and devotion in dealing with Freud, as depicted in this book, were matched only by his patient's unfailing strength and courage in undergoing the ordeals he had to face.

Because of this experience it is understandable that Schur should have undertaken to make a psychoanalytic investigation of Freud's ideas about death and dying, using his personal knowledge of Freud during the last period of his life together with Freud's formal writings on the subject and the relevant material contained in Freud's voluminous correspondence, especially with Fliess. However, the book that emerges seems to struggle with an identity problem since it can be considered as a biography (or more properly, a memoir), a discussion of Freud's ideas about death and dying and how he arrived at them, and finally an analysis of Freud by Schur. The author does not succeed in integrating these elements into a coherent whole, so that the reader is left with a sense of uncertainty about where the book is going and what the author is trying to do.

As a biography, the book comes alive in a special way after Schur enters the picture in 1929 and we learn the details of Freud's struggle with the disease that was gradually eating away his jaw and mouth. The contrast between his iron control in dealing with the consequences of his illness and his inability or refusal to give up the cigar smoking that was responsible for it is astounding. Freud's belief that he could not work without smoking and that he would not live without working never could be shaken by events or by persuasion.

Also, we are once more impressed by what an intensely private man Freud was. For someone who spent ten years in self-analysis, who published accounts of his dreams, and who had such an intimate correspondence with Fliess, we know very little about his feelings and his relationships with his family. Over and over again we read both Freud's and Schur's interpretations of the effect on him of the death of his next younger brother, Julius, when Freud was not quite two years old, but we learn almost nothing about his relationship with his wife, who remains a somewhat enigmatically absent figure in the book.

Schur sees Freud's need to come to terms with the death of his father and his own death fears and fantasies as one of the important stimuli for his self-analysis. There is a good deal of interest in following Schur's attempts to relate Freud's writings about death, especially his formulation of the death instinct, to the events in his life as revealed especially by biographical events such as concurrent illness and by his letters to Fliess.

But ultimately, the very cleverness and ingenuity of these formulations and the way in which the unconscious is used as a panchrest to explain and

tie together so many different phenomena become wearisome and do not convince. It is interesting to note that toward the end of his life, Freud had very little to say about the death instinct as applied to his own condition. Rather, he talked about himself and his fate in the much more simple human terms appropriate to a gifted old man caught in a struggle between his desire to live and to continue to create and a wish to escape from his torture.

Schur's attempts to analyze Freud—that is, his attempts to interpret and explain the psychic determinants of Freud's attitudes about death and dying, have some value. For instance, one can accept Schur's point that Freud's otherwise inexplicable devotion to and reliance on Fliess was a product of Freud's need to use Fliess as a transference figure in his own analysis. However, Schur's attempt to be Freud's analyst founders on the rock of Schur's complete neglect of the influence of his own attitudes toward Freud, that is, his own transference (or possibly one should say countertransference) distortions toward the man he was analyzing. An attitude of reverence and awe, although it may be appropriate, does not lend itself very well to a meaningful exploration of the unconscious motivation behind the revered individual's behavior.

What one is finally left with after reading this book is a sense of the towering human qualities of Sigmund Freud. At the age of 80, in the grip of the terminal phase of his long, debilitating illness, he was able to close a letter to the American poet Hilda Doolittle with the following sentence: "Life at my age is not easy, but spring is beautiful and so is love."

PAUL CHODOFF, M.D.
Washington, D.C.

DYNAMICS OF INSTITUTIONAL CHANGE: THE HOSPITAL IN TRANSITION. By Milton Greenblatt, M.D., Myron R. Sharaf, Ph.D., and Evelyn M. Stone. Pittsburgh: University of Pittsburgh Press, 1971, 257 pp., \$8.95.

In this age, as in many others in the past, about all that one can be sure of is that there will be many changes soon. The difference at present is that change is characterized not only by personnel changes in all human activities but by challenges to practically every principle or practice that most of us had thought was desirable and relevant. Psychiatry is no exception; we have many people, even in our own ranks, who apparently view the discipline as outmoded, useless, or even a part of the problem it is attempting to solve. Similarly, education itself (or at least the formal attempts to promote it) is being attacked with a fervor bordering on fanaticism. Many years ago Santayana defined a fanatic as one who redoubles his energy as he loses sight of his aim.

But rapid change or not, mental illness and ig-

norance will not disappear if the disciplines devoted to their understanding and amelioration are removed from the scene. What some impatient critics have failed to realize is that their overfeverish attempts to promote change by attacking institutions, rather than by trying to improve them, usually result in failure to achieve the desired results. Admittedly, violence in deed or word has sometimes produced reforms—but more often than not it has made matters worse.

Greenblatt and his colleagues have written a book on change that is of immense value to all administrators of psychiatric facilities. This is not a "how to do it" book, but a lucid description of the practical, theoretical, and philosophical problems facing the administrator when numerous contradictory and function-limiting demands are made upon him. Thus it can be helpful to any fledgling administrator, no matter what type of institution he may be responsible for.

The institution most often under specific discussion is Boston State Hospital, a hospital that not only had a series of problems of great magnitude and urgency, together with all the limitations imposed by a state government, but that also had the good fortune to be directed by Dr. Walter Barton, Dr. Greenblatt, and now Dr. Jonathan Cole. Practically every issue of current interest in mental health programs is treated with wisdom and understanding. Relations with the surrounding community and how to improve them are stressed. Philosophy of treatment, relations among staff members, the special problems of adolescents, rehabilitation, the use of volunteers, and psychiatric education and research—all receive sensitive and perceptive consideration.

Any new psychiatric administrator who doesn't read this book is going to have to learn many things the hard way. Indeed, there is much in it that is of value for any administrator of a large organization or for any person who is in the position of being a change agent in his community. Through application of its principles, a real beginning can be made toward attaining stability through change.

DANA L. FARNSWORTH, M.D.

Boston, Mass.

THE INSTITUTE OF LIVING: THE HARTFORD RETREAT, 1822-1972. By Francis J. Braceland, M.D. Hartford, Conn.: Institute of Living, 1972, 239 pp., \$10.

Hospital psychiatry had its origins in America in a general hospital in Philadelphia (the Pennsylvania Hospital, 1752) and in a state-supported mental hospital in Williamsburg, Va. (the Eastern Lunatic Asylum, 1773). In 1808 the New York Hospital first provided a separate unit for mental patients in its back yard, but another nine years

would elapse before mental patients would be admitted to private hospitals that specialized in disorders of the mind. Between 1817 and 1823, four private mental hospitals admitted their first patients: Friends Asylum, Philadelphia (1817), McLean Hospital, Waverly, Mass. (1818), Bloomingdale Hospital, White Plains, N.Y. (1821), and the Hartford Retreat, Hartford, Conn. (1824).

To celebrate the sesquicentennial of this last, now the well-known Institute of Living, Francis Braceland has written this lively and informative book. The Hartford Retreat was a product of the united efforts of the members of the Connecticut Medical Society, who had surveyed the state to ascertain the number of insane in need of treatment. These men patterned the hospital after the Society of Friends's York Retreat in England. (This Quaker institution served as the inspiration for a number of early American asylums.)

In selecting Eli Todd as its first superintendent, the Retreat started a long tradition of excellent leaders. Former heads include Amariah Brigham, John S. Butler, Henry P. Stearns, C. Charles Burlingame, and Braceland himself. Their contributions to American psychiatry are vast. Brigham founded the *American Journal of Insanity* in 1844; as the first psychiatric journal in English in the world, it continues today as the *American Journal of Psychiatry* under the editorship of Dr. Braceland. Both Brigham and Butler were founders of the American Psychiatric Association as it is now known; they served, respectively, as Vice-President and President. Dr. Braceland has also served as President of the Association, and although another Retreat leader, C. Charles Burlingame, was nominated for the presidency, he was defeated in a last-minute revolt on the floor.

The book is built around the careers of Retreat superintendents against a general historical overview. Dr. Braceland keeps the reader constantly informed on national movements (and city and state events when pertinent), the trend of social forces, and the impact of international medicine. Most of the figures are well known, but others emerge from the pages of history for the first time. There is fresh and useful information about the remarkable Eli Todd, who inspired so many in the early years of American psychiatry. (I look forward to a full-length study of this extraordinary man, which he so richly deserves.)

In the post-Civil War period, Dr. Braceland depicts a Szaszian-type movement, with lurid exposés of patients being railroaded into insane asylums (and, of course, some were), debate about liberty and rights, and subsequent law suits with correlative reform legislation. Also included are some of the recurrent problems of hospital administration—notably, the attitude of local fathers toward tax payments. One of the most ex-

citing narratives is that of the Retreat's changing role within the community after 1950. Incidentally, Dr. Braceland did not write the chapter on his own administration.

This is an excellent book; Dr. Braceland is too apologetic about its production "under forced draft." Although it is not a definitive history (and is not intended to be), it is an informative, warm, and important account of a venerable and vital institution that has been one of the most important in the history of American psychiatry.

ERIC T. CARLSON, M.D.
New York, N.Y.

CONSULTATION AND COMMUNITY ORGANIZATION IN COMMUNITY MENTAL HEALTH NURSING. By *Grace W. Deloughery, R.N., M.P.H., Ph.D., Kristine M. Gebbie, R.N., M.N., and Betty M. Neuman, R.N., M.S.* Baltimore: Williams & Wilkins Co., 1971, 214 pp., \$8.75 (paper).

This much-needed and well-written book, designed to serve as a base for classroom study and guide for practice for nurses in graduate and post-graduate study and for nurse practitioners, provides a theoretical framework for consultation and community organization in community mental health nursing. Although it is geared specifically to nurses, it presents many concepts that are generic to all community mental health professionals. Thus it is hoped that this welcome addition to the literature will enjoy a wide audience.

The authors, community mental health nursing faculty at the University of California at Los Angeles, launch their discussion with a brief overview of several interrelated historical dimensions of the mental health movement. They deftly weave this background material into the larger tapestry of the book as they develop the theory of mental health consultation and detail guidelines for its application in practice.

The definitions of consultation as a general concept and of mental health consultation as a particular application of the consultative process receive considerable attention. This discussion assists the reader in understanding the consultative process model, which is initially limited, for the purpose of clarity, to one consultee and then expanded to involve a group. Three phases of the consultative process are identified and discussed. This is followed by a section focused on the sociological concepts of role and function and specifically on how the mental health consultant's role and function influence his application of the process with the consultee. Evaluation as a necessary dimension of the consultative role is developed by an examination of the process itself and of the consultant qua consultant.

Following this detailed presentation of community mental health consultation, the authors

direct the discourse to the level of community organization and program planning and elaborate such concepts as power structure, planned change, change agent, conflict, and the pace of change. Since communities function within the larger context of local, state, and federal governments, the interplay of the formal and informal groups at these various government levels and their impact on the delivery of mental health services are discussed. Finally, summarizing the current state of knowledge, the authors look to the future and consider expansion of services, future refinement of roles and theories, and inclusion of mental health in comprehensive health planning.

Throughout the text the authors make clear not only their philosophical and professional orientation, but also their biases. In addition, they sprinkle the chapters with pithy, straightforward, and factual statements about nursing and nurses rather than reverting to the tired rhetoric all too often used by nurses describing nursing. For this reason I found the book refreshing; for the reasons outlined earlier, I found it stimulating in its logical development of ideas and useful in its approach to application of theory in community mental health nursing.

ANNE J. DAVIS, PH.D., R.N.
San Francisco, Calif.

MODERN PERSPECTIVES IN ADOLESCENT PSYCHIATRY. Edited by *John G. Howells, M.D., D.P.M.* New York: Brunner/Mazel, 1971, 511 pp., \$20.

This book contains such a wide scope and such a variety of perspectives on adolescence that it has a diffuse, rather than a concentrated, impact upon the reader. This diversity of perspectives and their qualitative variances emphasize to me a lack of scientific and literary integration, rather than a sparkling diversity of integrated viewpoints. It is this roller-coaster effect upon the reader that is so distracting in this otherwise interesting book.

For example, some articles tend to be primarily descriptive ("Family Group Therapy" by John Howells), others mainly statistical ("Normal Sexuality in Adolescence" by Michael Schofield), while others are primarily reports of case histories ("Obesity in Adolescence" by Hilde Bruch). Commingled with these differences are reports from different countries and cultures. This lack of cohesiveness in approach, method, and writing style detracts from a book containing a great deal of valuable information.

The value and attractiveness of having authors from different countries and cultures all focusing on a common topic cannot be doubted. But it would have enhanced the continuity of the book if they had—from their differing viewpoints—discussed clinical cases, cultural variances in health

statistics, current work or research in new therapies, and so forth, instead of mixing methods, cultures, topics, and styles hodgepodge fashion throughout the book.

It also seemed unusual that a book containing a number of articles and one major section on "Normal Sexuality in Adolescence" did not include mention of masturbation, let alone a discussion of contemporary attitudes and practices during adolescence.

This book contains useful information, and I am distressed that its faults as an integrated piece of scientific literature make it less useful than it should be.

RICHARD E. DAVIS, M.D.
Norfolk, Va.

READING AND ITS DIFFICULTIES. By *M.D. Vernon, M.A., Sc.D.* New York: Cambridge University Press, 1971, 201 pp., \$10.50.

One more book on reading and its difficulties would hardly be welcome unless its author had compiled the relevant clinical and experimental data on the mechanism of learning to read and on its disturbances and then appraised their validity. Vernon has done this without claiming to present a "complete exposition of all the psychological processes involved in reading, nor the causes of their variations and defects." Her book provides a clear, panoramic view of the current knowledge on reading and its disorders. It offers much material for building hypotheses for diagnosticians and educators of poor readers.

Interest in reading and its difficulties has rapidly increased in the affluent societies of the Old and New Worlds in the past ten years. While illiteracy has decreased, the backward reader has replaced the uneducated and now presents a harder challenge. One-tenth to one-fourth of the pupils in our schools are either poor readers or nonreaders. Few communities have schools where poor readers are recognized early and given proper remedial instruction.

Vernon reminds us that although methods of teaching have been blamed for the problem, there is as yet no adequate understanding of the psychologic mechanisms on which learning to read is

based. It is reasonable to accept that learning to read is dependent on auditory, visual, and cognitive processes. Vernon points out that reading is a variable activity according to the degree of proficiency of the reader and that the psychologic processes involved are numerous and complex at different stages of the learning. As one might expect, failure is frequent. Among the psychologic mechanisms for learning to read, there are numerous sites where there could be an obstacle. If we accept that ability to learn to read depends on adequate perceptual and cognitive functions, we can regard reading disability as the result of developmental failure of these functions.

Vernon stresses the importance of conceptual reasoning in relation to reading: A high order of reasoning is involved in understanding the complex associations of letters, phonemes, and rules of spelling as well as in understanding the meaning of the text. However, the relationship of reading to intelligence, as measured with standard intelligence tests such as the Wechsler Intelligence Scale for Children, is not well understood.

In a final chapter entitled "Specific Developmental Dyslexia" (this actually is the subject of the entire volume), the current hypotheses on the cause of dyslexia are critically considered. The final section deals with the effect of remedial treatment and is a concise and clear review of the better known methods. The author concludes that different approaches are needed for different dyslexic pupils.

Phonic methods are appropriate for the primarily visual dyslexic, while whole-word methods are appropriate for the primarily auditory and linguistic dyslexic. The teacher should use those psychologic processes in which the child is more adept and at the same time try to overcome his weak processes with supplementary teaching. Tracing letters and writing and saying each phoneme after the teacher, as in the Fernald and the Gillingham-Stillman methods, seems to be the most successful approach to establishing the association of phoneme sequences to printed letter sequences and the synthesis of words and sounds or, as Vernon puts it, "grasping the correspondence between spatially extended letter sequences and temporally ordered phoneme sequences."

MANUEL R. GOMEZ, M.D.
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This Month's Reviewers

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Books Received

The following books have been received; the courtesy of the sender is acknowledged by this listing. Books of particular interest to the readers of this journal will be reviewed as space permits.

BODY, MIND, AND THE B VITAMINS. By *Ruth Adams* and *Frank Murray*. New York: Larchmont Books, 1972, 244 pp., \$1.50 (paper).

NERVES IN COLLISION. By *Walter C. Alvarez, M.D.* New York: Pyramid House, 1972, 209 pp., \$8.95.

SLAUGHTER OF THE INNOCENTS: A STUDY OF THE BATTERED CHILD PHENOMENON. By *David Bakan*. Boston: Beacon Press, 1972, 121 pp., \$2.95 (paper).

THE COMMUNITY MENTAL HEALTH CENTER: STRATEGIES AND PROGRAMS. Edited by *Allan Beigel, M.D.*, and *Alan I. Levenson, M.D.* New York: Basic Books, 1972, 416 pp., \$12.50.

FIFTY YEARS IN NEUROLOGY AND PSYCHIATRY. By *Abram Elting Bennett, M.D.* New York: Intercontinental Medical Book Corp., 1972, 166 pp., no price listed.

ACTIONS, STYLES AND SYMBOLS IN KINETIC FAMILY DRAWINGS (K-F-D). By *Robert C. Burns* and *S. Harvard Kaufman, M.D.* New York: Brunner/Mazel, 1972, 302 pp., \$12.50.

HELP YOURSELF TO HEALTH. By *Linda A. Clark, M.A.* New York: Pyramid House, 1972, 262 pp., \$7.95.

THE JOY OF SEX, illustrated ed. Edited by *Alex Comfort, M.B., Ph.D.* New York: Crown Publishers, 1972, 253 pp., \$12.95.

CBE STYLE MANUAL, 3rd ed. By the *Committee on Form and Style of the Council of Biology Editors*. Washington, D.C.: American Institute of Biological Sciences, 1972, 277 pp., \$6.

THE PSYCHOANALYTIC PROCESS: A CASE ILLUSTRATION. By *Paul A. Dewald*. New York: Basic Books, 1972, 655 pp., \$15.

THE HOME AND THE SCHOOL: A STUDY OF ABILITY AND ATTAINMENT IN THE PRIMARY SCHOOL (1964). By *J.W.B. Douglas*. New York: Ballantine Books, 1972, 217 pp., \$1.25 (paper).

MENTAL HEALTH BOOK REVIEW INDEX, VOL. 17. Compiled by the *Editorial Committee and Contributing Librarians*. New York: Council on Research in Bibliography (c/o Research Center for Mental Health, New York University), 1972, 92 pp., \$10 (paper).

PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE (4th printing). By *Eliot Freidson, Ph.D.* New York: Dodd, Mead & Co., 1972, 382 pp., no price listed.

HYPNOSIS: RESEARCH DEVELOPMENTS AND PERSPECTIVES. Edited by *Erika Fromm* and *Ronald E. Shor*. Chicago: Aldine-Atherton, 1972, 638 pp., \$27.50.

RELIGION AND BEREAVEMENT: COUNSEL FOR THE PSYCHICIAN, ADVICE FOR THE BEREAVED, THOUGHTS FOR THE CLERGYMAN. Edited by *Dr. Austin H. Kutscher* and *Lillian G. Kutscher*. New York: Health Sciences Publishing Corp., 1972, 224 pp., \$12.50.

THE MIND OF ADOLF HITLER: THE SECRET WARTIME REPORT. By *Walter C. Langer*. New York: Basic Books, 1972, 263 pp., \$10.

ALPHA BRAIN WAVES. By *Jodi Lawrence*. Los Angeles: Nash Publishing, 1972, 230 pp., \$7.95.

SICKLE CELL: A COMPLETE GUIDE TO PREVENTION AND TREATMENT. By *Shirley Motter Linde, M.S.* New York: Pavilion Publishing Co., 1972, 179 pp., \$2 (paper).

NEUROPHARMACOLOGY AND BEHAVIOR. By *F.G. Longo*. San Francisco: W.H. Freeman and Co., 1972, 184 pp., \$6.95.

BASIC PSYCHIATRY: A PRIMER OF CONCEPTS AND TERMINOLOGY IN PROGRAMMED FORM, 2nd ed. By *James L. Mathis, M.D.*, *Chester M. Pierce, M.D.*, and *Vladimir Pishkin, Ph.D.* New York: Appleton-Century-Crofts (Meredith Corp.), 1972, 140 pp., no price listed (paper).

RECENT ADVANCES IN STUDIES OF ALCOHOLISM: AN INTERDISCIPLINARY SYMPOSIUM. Edited by *Nancy K. Mello, Ph.D.*, and *Jack H. Mendelson, M.D.* Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, National Institute of Mental Health, 1972, 870 pp., \$3.75 (paper).

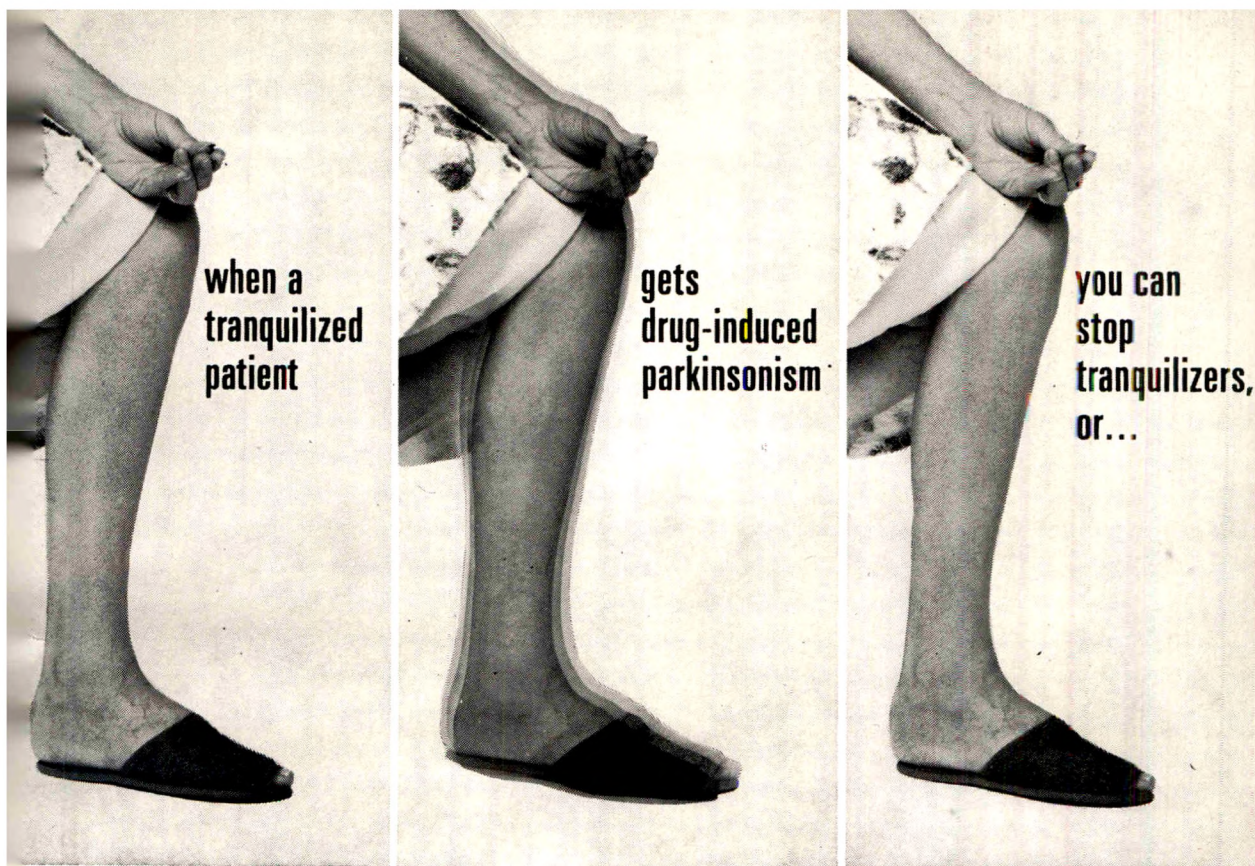
MENTALLY RETARDED CHILDREN: AN INTENSIVE STUDY OF 100 CASES. By the *Moribai Thackersey Institute of Research in Mental Retardation*. Bombay, India: Popular Prakashan, 1972, 103 pp., Rs 28.

THE CHILD'S DISCOVERY OF HIMSELF (formerly *EXISTENTIAL CHILD THERAPY* [1956]). Edited by *Clark Moustakas*. New York: Ballantine Books, 1972, 236 pp., \$1.25 (paper).

A NEW BREED OF DOCTOR. By *Alan H. Nittler, M.D.* New York: Pyramid House, 1972, 193 pp., \$8.55.

A MINGLED YARN: CHRONICLE OF A TROUBLED FAMILY. By *Beulah Parker, M.D.* New Haven, Conn.: Yale University Press, 1972, 333 pp., \$7.95.

- BEREAVEMENT: STUDIES OF GRIEF IN ADULT LIFE.** By *Colin Murray Parkes, M.D., D.P.M.* New York: International Universities Press, 1972, 226 pp., \$10.
- MY ALCOHOLIC VIRGIN.** By *L.W. Parratt, M.D.* New York: Vantage Press, 1972, 447 pp., \$7.95.
- DIAGNOSIS OF STUPOR AND COMA,** 2nd ed. By *Fred Plum, M.L., and Jerome B. Posner, M.D.* Philadelphia: F.A. Davis Co., 1972, 275 pp., \$9.50.
- HUMAN PEESONALITY: TOWARDS A UNIFIED THEORY.** By *Barrie Rogers.* New York: Vantage Press, 1972, 233 pp., \$6.95.
- WHERE THE WASTELAND ENDS: POLITICS AND TRANSCENDENCE IN POSTINDUSTRIAL SOCIETY.** By *Theodore Roszak.* Garden City, N.Y.: Doubleday & Co., 1972, 492 pp., \$10.
- INFANTILE AUTISM: CONCEPTS, CHARACTERISTICS AND TREATMENT.** Edited by *Michael Rutter, M.D., D.P.M.* Baltimore: Williams & Wilkins Co. (exclusive U.S. agents), 1972, 319 pp., \$13.75.
- NATURE AND NURTURE IN ALCOHOLISM.** Edited by *Frank A. Seixas, Gilbert S. Omenn, E. David Burk, and Suzie Eggleston.* *Annals of the New York Academy of Sciences*, vol. 197, 1972, 229 pp., no price listed.
- IN PRAISE OF MADNESS: REALNESS THERAPY—THE SELF RECLAIMED.** By *Paul J. Stern, Ph.D.* New York: W.W. Norton & Co., 1972, 125 pp., \$5.95.
- A SYNOPSIS OF CONTEMPORARY PSYCHIATRY,** 5th ed. By *George A. Ulett, M.D., Ph.D.* St. Louis: C.V. Mosby Co., 1972, 348 pp., \$10.90.
- A PRIMER OF MISBEHAVIOR: AN INTRODUCTION TO ABNORMAL PSYCHOLOGY.** By *George R. Wesley, Ph.D.* Chicago: Nelson-Hall Co., 1972, 196 pp., \$6.95.
- MENTAL RETARDATION: AN ANNUAL REVIEW, VOL. IV.** Edited by *Joseph Wortis, M.D.* New York: Grune & Stratton, 1972, 230 pp., \$15.75.



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1. Lapolla, A. and Nash, L. R.: *Current Therapeutic Research* 7:536 (Sept.) 1965. 2. Sheppard, C. and Merlis, S.: *American Journal of Psychiatry* 123:886 (Jan.) 1967.

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ing to fall asleep, relaxes his muscles, and in an unguarded moment eventually does. Still, he may sleep in what has been called "a state of alarm."

Unsweet dreams. The very fears associated with falling asleep can come to be incorporated into the sleep state itself. J. G. Frazer in *The Golden Bough*, for instance, tells how some primitive tribes believe the soul leaves a sleeper's body and journeys to far places, always with risk. In a sample of 1320 modern dreams, 488 hostile acts were recorded as against 188 friendly ones; 64 percent of all dream emotions were negative or unpleasant.

What can be done

"Fatigue," Benjamin Franklin advised, "is the best pillow." Where the overall alertness is mild, the patient may simply need more exercise and fresh air during the day, or a long walk in the evening. Perhaps a warm bath before sleep, a glass of hot milk or a rubdown would relax him, or provide sufficient distraction from his worries to allow him to sleep through the night.

For the more-than-mild, a stronger calmativ such as a minor tranquilizer may help relieve daytime tension and thus set the stage for nighttime release. Difficult cases may call for an alternative,

such as psychiatric referral and/or hypnotic support. Clinicians look for several features when a hypnotic is indicated; effectiveness and a wide margin of safety are two important ones.

Why Noludar[®] 300 (methypylon) can help

An effective hypnotic. Noludar 300 is usually effective for the overall alert insomniac patient. It is a nonbarbiturate that usually induces sleep within 45 minutes and provides sleep for 5 to 8 hours.

The safety factor. In over 17 years of outpatient use, Noludar has been prescribed for some 10 million patients for a total of about 550 million doses (200 mg and 300 mg) with less than 0.005% incidence of overdosage (virtually all recovered).^{*} At recommended dosages there is rare paradoxical excitation and little suppression of respiratory or cardiovascular function. A refreshed quality of awakening, usually with little "hang-over," helps support the daytime activity. Total daily intake of Noludar should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

^{*}Data on file, Department of Medical Investigation, Hoffmann-La Roche Inc., Nutley, N.J. Other references available on request.

Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: As a hypnotic for relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence have been reported infrequently. Withdrawal symptoms,

when they occur, tend to resemble those associated with withdrawal of barbiturates and should be treated in a similar fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be limited without adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

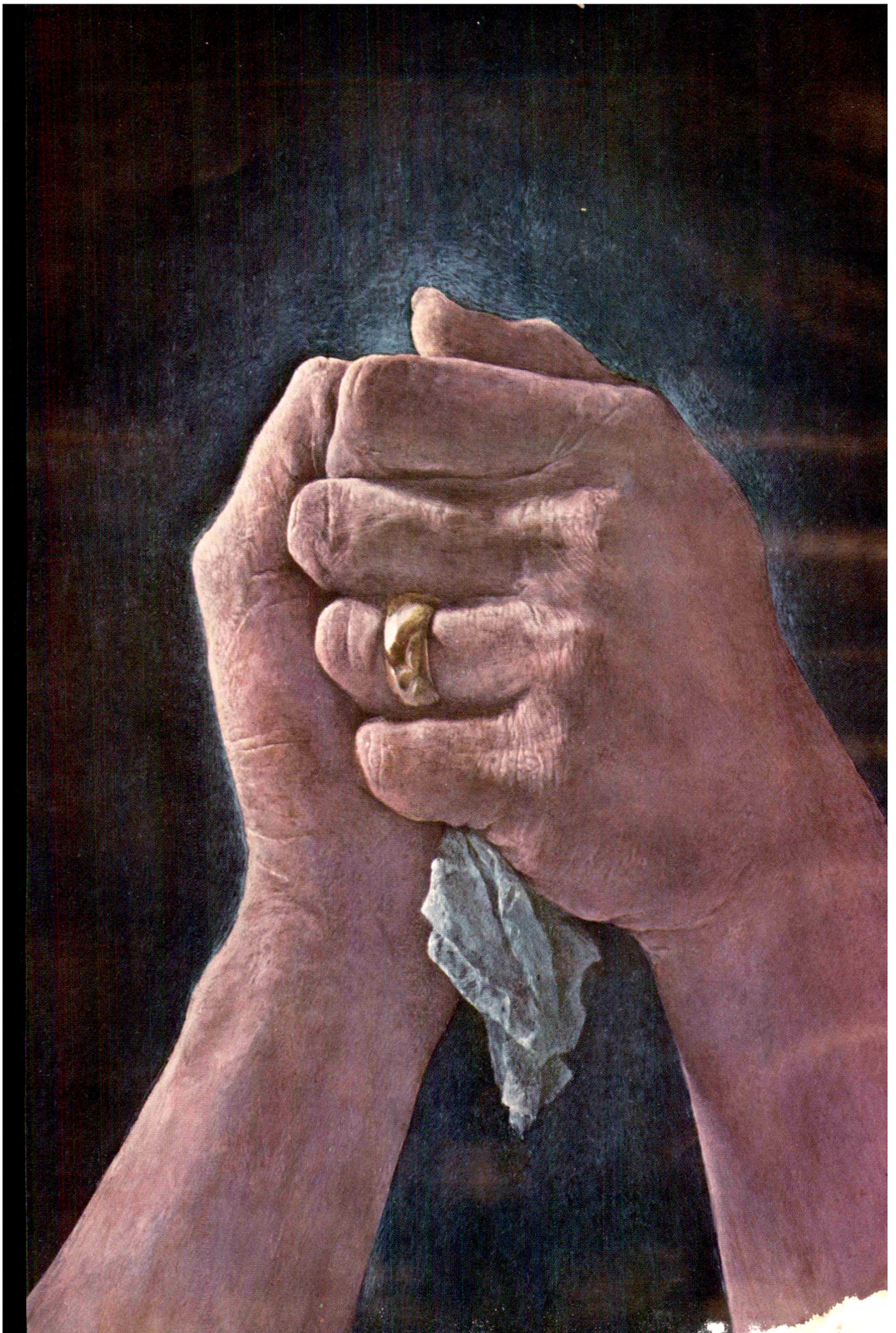
Usage in Children: Not recommended in children under 3 months of age.

PRECAUTIONS: Total daily intake should not exceed 400 mg, as greater

amounts do not significantly increase hypnotic benefits. Observe usual precautions in hepatic or renal disorders. Perform periodic blood counts if used repeatedly or over prolonged periods.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

SUPPLIED: Capsules containing 300 mg methypylon.



The emotional symptoms that go hand in hand...

Diagnosed psychoneurotic anxiety and depression.

Increasingly, physicians have come to recognize that, "Patients seldom, if ever, appear with depression or anxiety alone; more often they have both in varying degrees."¹

Clearly, this poses a problem in the patient treated with a tranquilizer or an antidepressant alone: "The combination of anxiety and depressive states often makes the diagnosis confusing. Some apparent anxiety neurotic states merge into clear-cut psychotic depressions. When the patient recovers from the depressive episode, he is left with residual anxiety states. The anxious neurotic background may predispose to a psychotic depression. It is important to recognize the predominant affective reaction in order to give proper therapy."²

Since psychoneurotic anxiety and depression may coexist, there is often a place for Sinequan (doxepin HCl).

Because Sinequan is the first single agent effective against a broad range of symptoms of both anxiety and depression.

Its marked activity against the common symptoms of both anxiety and depression—apprehension, insomnia, fatigue, functional complaints—may often eliminate the need for fixed combinations or admixtures of agents, with their inherent potential for two sets of adverse reactions.

And, although Sinequan itself is a potent antidepressant and tranquilizing agent, clinical experience has shown it to be well tolerated—even in the elderly. The nature and incidence of side effects compare favorably with those of other psychotropic drugs, the most common reactions being drowsiness and symptoms due to anticholinergic activity.

The frequent association and the difficulty in recognizing depression underlying anxiety make Sinequan a prime candidate in the choice of a drug to be employed routinely in the office management of diagnosed psychoneurotic anxiety, especially when depression may suppress therapeutic response.³

1. Claghorn, J.: Psychosomatics Supplement 11:438, Sept.-Oct., 1970.

2. Bennett, A.E.: G. P. 27:101, May, 1963.

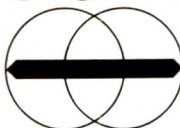
3. McLaughlin, B.: Psychosomatics Supplement 10:28, May-June, 1969.

**because
psychoneurotic
anxiety and depression
often coexist**

Sinequan®
DOXEPIN HCl



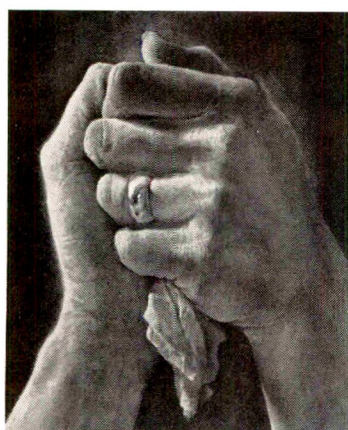
Starting dosage:
25 mg t.i.d.
for mild to moderate
symptomatology



Please see following page for adverse reactions, contraindications, warnings and precautions

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The tranquilizer that is an antidepressant.
The antidepressant that is a tranquilizer.



BRIEF SUMMARY

Sinequan (doxepin•HCl) Capsules

Contraindications. Sinequan (doxepin•HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin•HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin•HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin•HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be

discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin•HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin•HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin•HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin•HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin•HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin•HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation

have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin•HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100 and 1000.

More detailed professional information available on request.

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Mental Disorders/Suicide

This monograph presents an analysis of statistical data on two important health problems, considered here as separate issues. Although systematic annual morbidity statistics for mental disorders are nonexistent, extensive data exist for the United States on patterns of use of mental hospitals and other types of psychiatric facilities. The chapters dealing with mental disorders examine these data and provide information for evaluating mental health services. The section on suicide provides mortality rates derived from data on all such deaths occurring in the United States, and discusses demographic variables as well as various sociological and psychological theories about suicide.

Mental Disorders/Suicide

Morton Kramer, Earl S. Pollack, Richard W. Redick, and Ben Z. Locke
\$7.00

Vital and Health Statistics Monographs, American Public Health Association.

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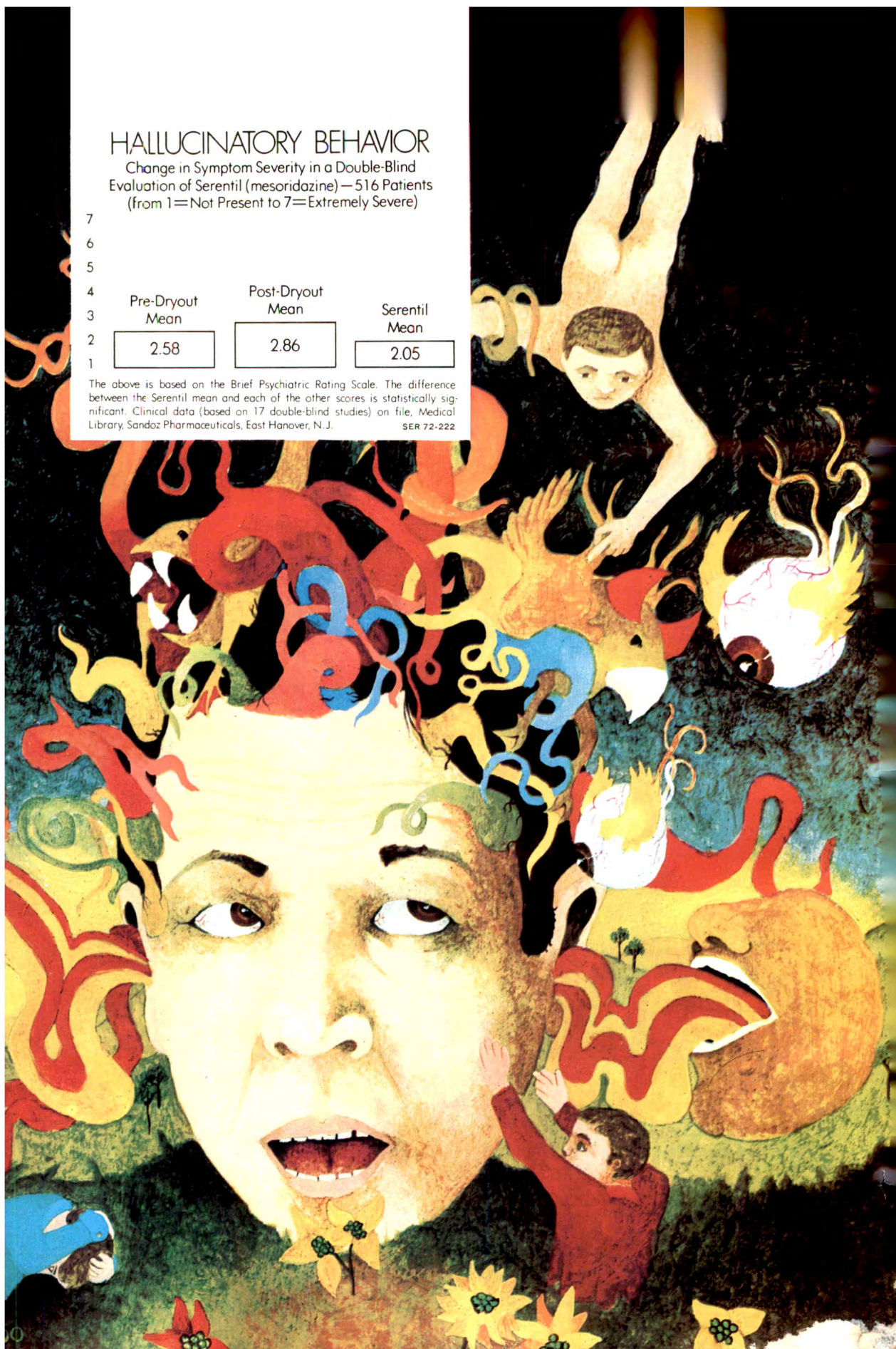
HALLUCINATORY BEHAVIOR

Change in Symptom Severity in a Double-Blind
Evaluation of Serentil (mesoridazine) — 516 Patients
(from 1=Not Present to 7=Extremely Severe)

7			
6			
5			
4			
3	Pre-Dryout Mean	Post-Dryout Mean	Serentil Mean
2	2.58	2.86	2.05
1			

The above is based on the Brief Psychiatric Rating Scale. The difference between the Serentil mean and each of the other scores is statistically significant. Clinical data (based on 17 double-blind studies) on file, Medical Library, Sandoz Pharmaceuticals, East Hanover, N.J.

SER 72-222



EMOTIONAL WITHDRAWAL
CONCEPTUAL DISORGANIZATION / ANXIETY
TENSION / HALLUCINATORY BEHAVIOR
SUSPICIOUSNESS / BLUNTED AFFECT

One or more
of these symptoms
in a schizophrenic is
an indication for
Serentil[®]
(mesoridazine)
Tablets 50 mg. (as the besylate)

 Serentil is also available in injectable form
(Ampuls 1 cc.: 25 mg. mesoridazine [as the besylate]. Inactive ingredients—
disodium edetate, U.S.P., 0.5 mg.; sodium chloride, U.S.P., 7.2 mg.; carbon
dioxide gas [bone dry], q.s.; water for injection, U.S.P., q.s. to 1 cc.) 

See next page for brief summary.

EMOTIONAL WITHDRAWAL
CONCEPTUAL DISORGANIZATION / ANXIETY
TENSION / HALLUCINATORY BEHAVIOR
SUSPICIOUSNESS / BLUNTED AFFECT

One or more of these symptoms
in a schizophrenic is an indication for



Contraindications: Severe central nervous system depression, comatose states, hypersensitivity.

Warnings: Increase dosage gradually to patients participating in activities requiring complete mental alertness (e.g., driving). The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus. Use in children under 12 is not recommended. Phenothiazines are capable of potentiating central nervous system depressants as well as atropine and phosphorus insecticides.

Precautions: Ocular changes (seen with other phenothiazines) have not been seen with Serentil (mesoridazine). Because of possible hypotensive reactions, caution in parenteral use is required. Reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection. Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. Blood dyscrasia (see with other phenothiazines) has occurred in a single case of transient granulocytopenia.

Adverse Reactions: Serentil (mesoridazine) has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds. *Central Nervous System:* Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos). *Autonomic Nervous System:* Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision. *Endocrine System:* Inhibition of ejaculation and lactation have been noted rarely. *Skin:* Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema. *Cardiovascular System:* Hypotension, tachycardia, EKG changes.

The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering

and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Serentil (mesoridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. There is no evidence that these changes are precursors of any significant disturbance of cardiac rhythm. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, and akinesia, occasionally persisting for several months or years especially in elderly patients with brain damage. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, weight gain, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia, behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

Dosage and Administration: ORAL: Should be adjusted to needs of the individual. Lowest effective dosage should always be used. When maximum response is achieved, dosage may be reduced gradually to maintenance level. *Schizophrenia:* For most patients, regardless of severity, starting dose of 50 mg. t.i.d. recommended. Usual optimum total daily dose range 100-400 mg. *Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome:* For most patients starting dose of 25 mg. t.i.d. recommended. Usual optimum total daily dose range 75-300 mg. *Alcoholism:* For most patients usual starting dose is 25 mg. b.i.d. Usual optimum total daily dose range 50-200 mg. *Psychoneurotic Manifestations:* For most patients usual starting dose is 10 mg. t.i.d. Usual optimum total daily dose range 30-150 mg. **INJECTABLE FORM:** For situations in which an intramuscular form of medication is indicated. For most patients a starting dose of 25 mg. is recommended, to be repeated in 30-60 minutes if necessary. Usual optimum total daily dose range 25-200 mg.

Before prescribing, consult package circular.

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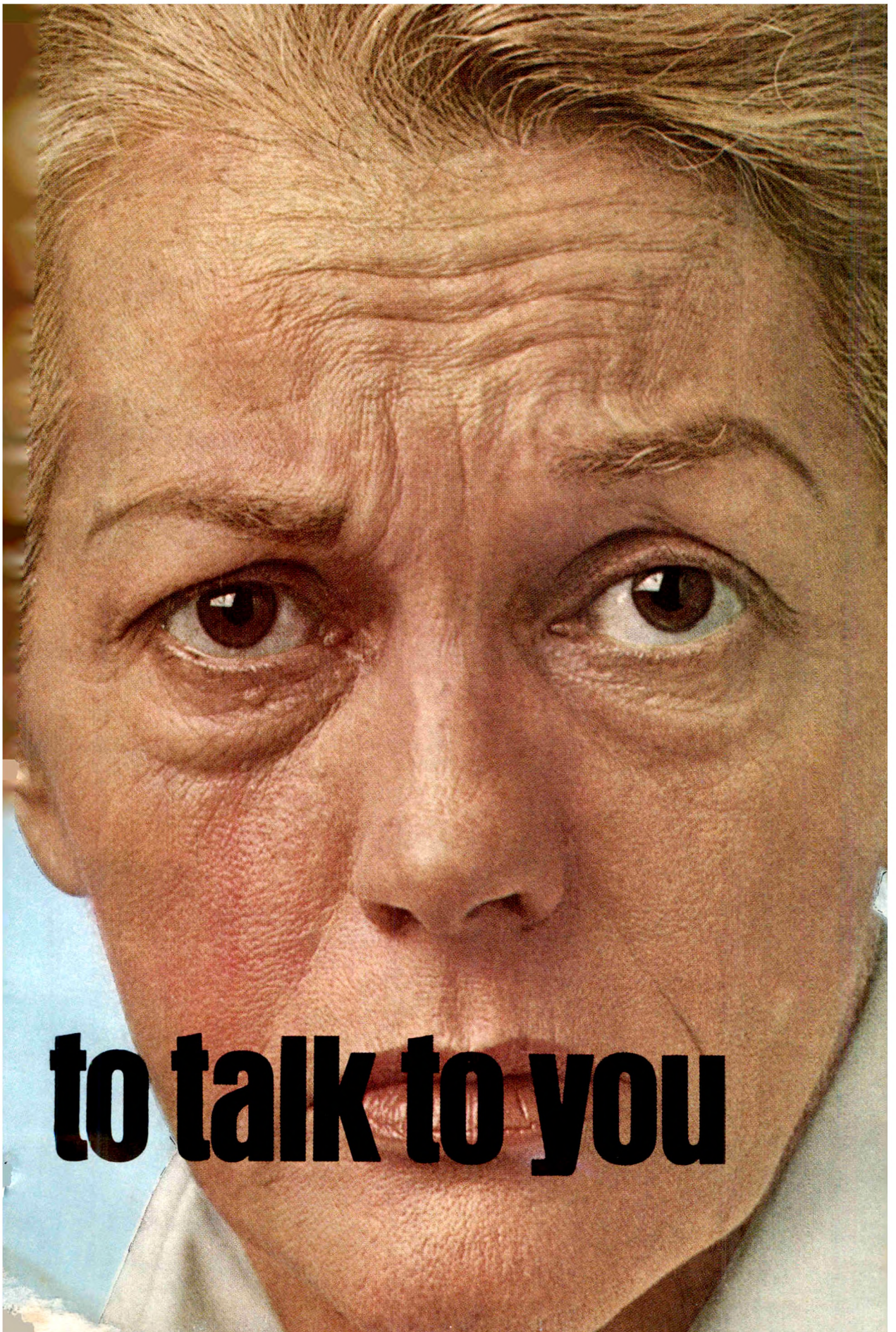
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Serax[®]
(oxazepam) 

*As with other CNS-acting drugs, patients should be cautioned against driving automobiles or operating dangerous machinery until it is known that they do not become drowsy or dizzy on oxazepam therapy. When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly or where a drop in blood pressure might lead to cardiac complications. Wyeth Laboratories Philadelphia, Pa. See important information on page after next.

too
She's [^]anxious



to talk to you

Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease.

Anxiety associated with depression is also responsive to oxazepam therapy.

This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients.

Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: Use in Pregnancy: Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias

When she's too anxious to talk to you

(including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

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ROCHE PSYCHIATRIC SERVICE INSTITUTE

MMPI REPORT

RPSI, NO: 20018
JAN. 18, 1972

CASE NO: 787503
AGE 40 MALE

HE SEEMS TO BE ATTEMPTING TO MINIMIZE OR DENY FAULTS IN HIMSELF. HE IS RESISTANT TO ADMIT TO PSYCHOLOGICAL PROBLEMS, PERHAPS BECAUSE HE PERCEIVES THEM AS WEAKNESSES. IN SOME NORMALLY FUNCTIONING INDIVIDUALS THIS APPARENT DEFENSIVENESS MAY REPRESENT SELF-ASSURANCE AND A GOOD SELF-CONCEPT. IN AN INDIVIDUAL WITH CURRENT DIFFICULTIES, HOWEVER, IT IS MORE LIKELY TO REPRESENT RESISTANCE AND RELUCTANCE TO ENTER TREATMENT.

THIS PATIENT HAS DIFFICULTY WITH IMPULSE CONTROL. ALTHOUGH HIS ANGER MAY SOMETIMES BE DIRECTLY EXPRESSED IN TENSE OUTBURSTS, HE IS MORE LIKELY TO REPRESS HIS HOSTILITY AND TO EXPERIENCE VAGUE PHYSICAL COMPLAINTS. HE IS SOMEWHAT DEPRESSED AND MAY BE UNSTABLE, TENSE, AND SUSPICIOUS AS WELL.

HE UTILIZES REPRESSION AND DENIAL IN RESPONSE TO EMOTIONAL PROBLEMS. HE MAY RESPOND TO SUGGESTION AND REASSURANCE BUT HE PROBABLY WILL RESIST A PSYCHOLOGICAL EXPLANATION OF HIS DIFFICULTIES. IN PERIODS OF PROLONGED EMOTIONAL STRESS HE MAY DEVELOP ANXIETY ATTACKS AND FUNCTIONAL COMPLAINTS.

THERE ARE SOME UNUSUAL QUALITIES IN THIS PATIENT'S THINKING WHICH MAY REPRESENT AN ORIGINAL INVENTIVE ORIENTATION OR PERHAPS SOME SCHIZOID TENDENCIES. FURTHER INFORMATION WOULD BE REQUIRED TO MAKE THIS DETERMINATION.

HE APPEARS TO BE AN IDEALISTIC, INNER-DIRECTED PERSON WHO MAY BE SEEN AS QUITE SOCIALLY PERCEPTIVE AND SENSITIVE TO INTERPERSONAL INTERACTIONS. HIS INTEREST PATTERNS ARE QUITE DIFFERENT FROM THOSE OF THE AVERAGE MALE. IN A PERSON WITH A BROAD EDUCATIONAL AND CULTURAL BACKGROUND THIS CONCERN WITH SOCIAL ISSUES, AND AN ABILITY TO AS SELF-AWARENESS CONCERN WITH SOCIALLY ISSUES, AND AN ABILITY TO COMMUNICATE IDEAS CLEARLY AND EFFECTIVELY. IN SOME MEN, HOWEVER, THE SAME INTEREST PATTERN MAY REFLECT A REJECTION OF MASCULINITY ACCOMPANIED BY A RELATIVELY PASSIVE, EFFEMINATE NON-COMPETITIVE PERSONALITY.

HE APPEARS TO BE AN UNASSUMING, DEPENDABLE PERSON WHO SHOWS GOOD JUDGMENT AND COMMON SENSE. HE MAY BE SEEN BY OTHERS AS RESPONSIBLE, STABLE AND CONSCIENTIOUS AND PERHAPS SOMEWHAT MORALISTIC.

NOTE: ALTHOUGH NOT A SUBSTITUTE FOR THE CLINICIAN'S PROFESSIONAL JUDGMENT AND SKILL, THE MMPI CAN BE A USEFUL ADJUNCT IN THE EVALUATION AND MANAGEMENT OF EMOTIONAL DISORDERS. THE REPORT IS FOR PROFESSIONAL USE ONLY AND SHOULD NOT BE SHOWN OR RELEASED TO THE PATIENT.

ROCHE

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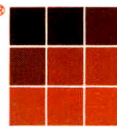
ROBERT J. LOWE

A major need
in establishing rapport
with the withdrawn,
uncommunicative patient...

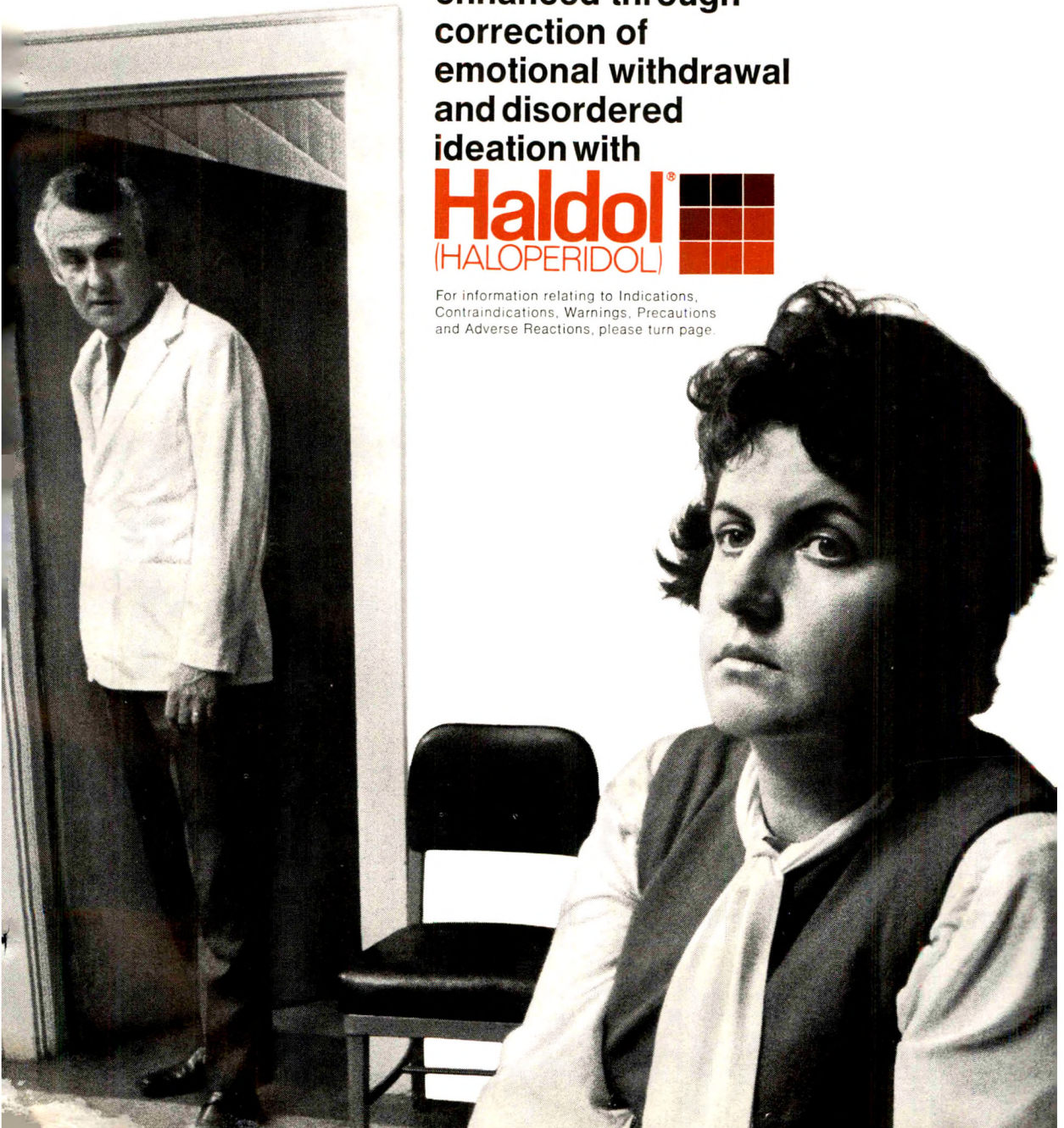
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often significantly
enhanced through
correction of
emotional withdrawal
and disordered
ideation with

Haldol[®]
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For information relating to Indications,
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and Adverse Reactions, please turn page.





a first choice for prompt rapport in establishing the therapeutic alliance

A Dosage Form for Every Need:

 **4 tablet strengths** for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg. and 5 mg.

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Summary of Directions for Use

Indications: For the treatment of such symptoms as moderate to severe agitation, anxiety and tension, assaultiveness, delusions, hallucinations, hostility, and hyperactivity when they are manifestations of psychosis including schizophrenia, the manic type of manic depressive illness, or psychotic reactions associated with organic brain syndromes or mental retardation. For the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: *Usage in Pregnancy*—Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children—Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, epinephrine should not be used since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold, although it will not increase the effects of anticonvulsant medication. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of

interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intra-ocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL. When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: *CNS Effects:* **Extrapyramidal Reactions**—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. *Cardiovascular Effects:* Tachycardia and hypotension. *Hematologic Effects:* Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. *Liver Effects:* Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. *Dermatologic Reactions:* Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. *Endocrine Disorders:* Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. *Gastrointestinal Effects:* Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. *Autonomic Reactions:* Dry mouth, blurred vision, urinary retention and diaphoresis. *Respiratory Effects:* Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed.

*With 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4 ± 0.2.

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contribution to
continued rapport
with patients
with senile
mental syndrome...

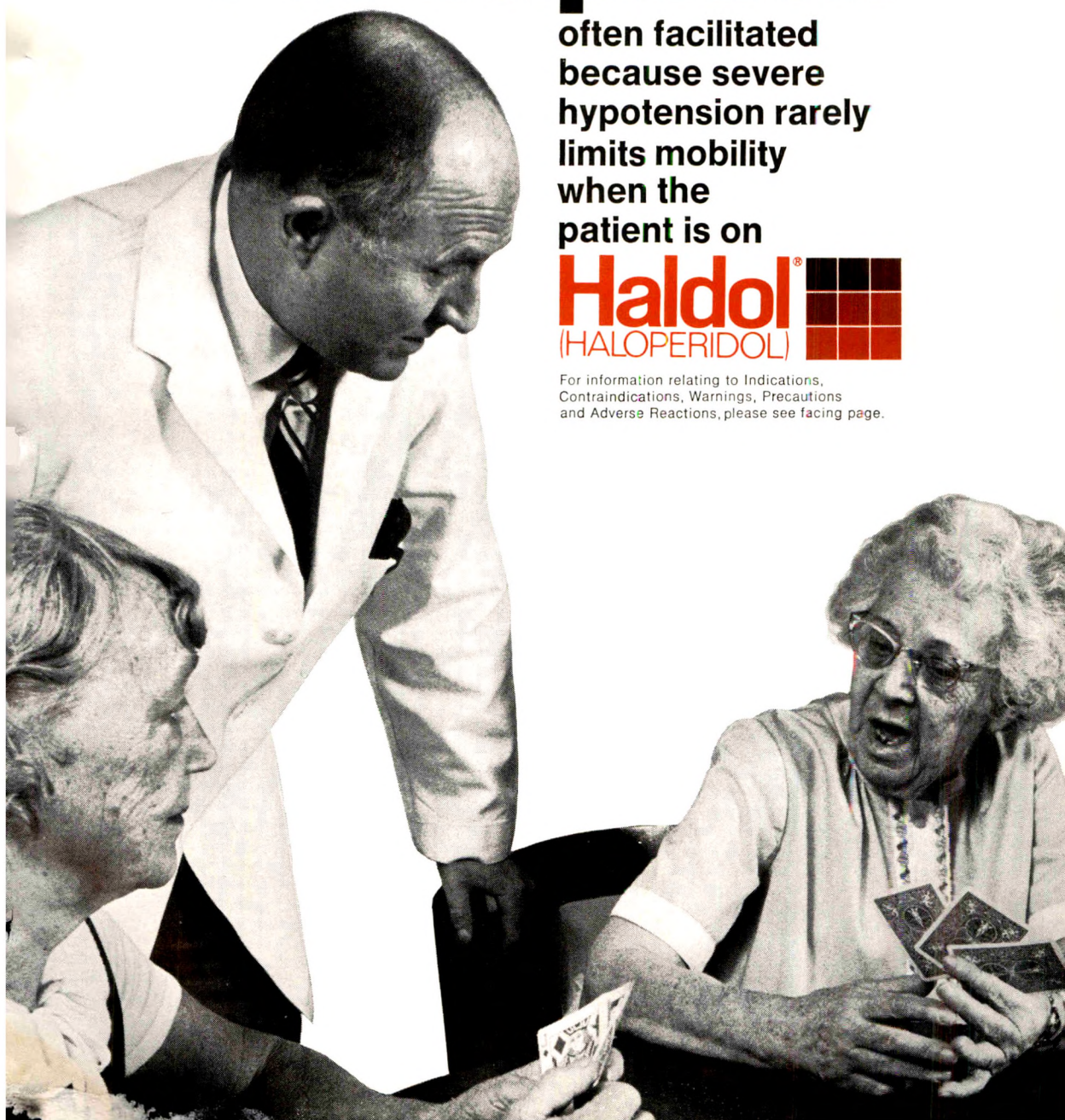
Participation

often facilitated
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hypotension rarely
limits mobility
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patient is on

Haldol[®]
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Helping the MBD child achieve



Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children

—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

The characteristic signs most often observed are chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; specific learning disabilities; perceptual motor impairment; minor neurological signs and abnormal EEG. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these signs.

Drug treatment is not indicated for all children with MBD. Appropriate educational placement is essential and psy-

chological remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established.

Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior

seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anti-convulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension.

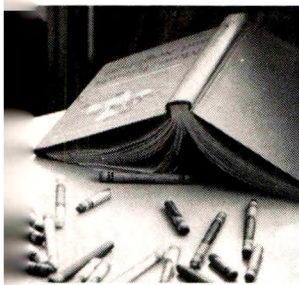
Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh possible risks.

his full potential



Here is a child who seems to get very little out of school.

He can't sit still. Doesn't take direction well. He's easily frustrated, excitable, often aggressive. And he's got a very short attention span.

The teacher may seek professional help because of his disturbing influence in the classroom. But the real tragedy is that he's simply not developing basic learning skills. And failure to learn in these early years could mean he'll never catch up.

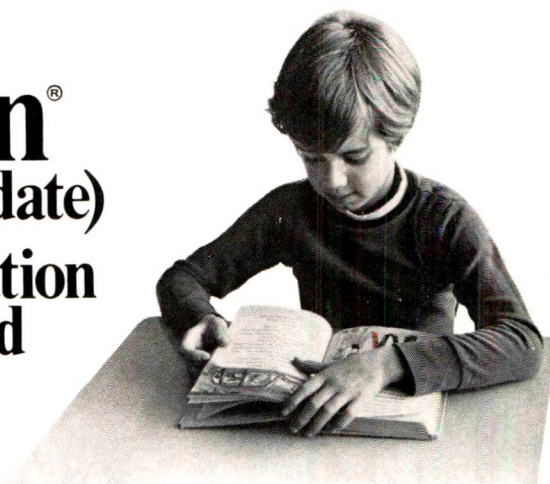
Yet this tragic waste of human potential could be averted. For the

problem is more than the mischief and hyperactivity that occur as a phase of normal growth. He is a victim of Minimal Brain Dysfunction, a diagnosable disease entity that generally responds to treatment programs.

And Ritalin can be an important part of the total rehabilitation program which includes remedial measures at home and at school. Ritalin, an effective and well-tolerated CNS stimulant, can help control hyperactivity and other symptoms that so often beset the MBD child.

Of course, Ritalin is not indicated for childhood personality and behavior disorders not associated with MBD.

Ritalin[®] (methylphenidate) when medication is indicated



Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (eg, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug

if paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.

Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.

Consult complete product literature before prescribing.

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C I B A

repeated biting of lip,
tense facial expression,
fingernails bitten down

complained of waking
early in the morning

patient was agitated,
restless, and irritable

finds it almost
impossible to start
housework
every morning



THE PATIENT'S ANXIETY AND DEPRESSION NEED TREATMENT...
Her signs and symptoms suggested it – Your complete workup confirmed it.

noticed that palms
were moist

thinks she has a
"nervous stomach"

said she lost
interest in
most things

said she was tired
and listless most of
the time



Clinically significant anxiety may manifest itself by a variety of signs and symptoms, all of which are more readily apparent than those of depression. As a result, the coexisting depression that so frequently exists is often overlooked.

Many such patients are being treated with just a tranquilizer and nothing more. This can complicate or expose the underlying depression and even delay symptomatic improvement.

That's why an obviously anxious patient should be given a thorough evaluation with a complete history and physical examination.

If coexisting depression is affirmed, the physician should consider a medication specifically formulated to aid in treating the anxiety-depression syndrome.

TRIAVIL is that kind of agent.

Indicated for moderate to severe anxiety with depression, TRIAVIL is a dual component product consisting

of perphenazine, a highly effective tranquilizer *and* amitriptyline HCl, an effective antidepressant. Working together, these two components treat *both* anxiety and depression, often relieving many of the somatic complaints so commonly associated with this disorder.

The drug may impair alertness and can potentiate the response to alcohol. Should not be used during the acute recovery phase following myocardial infarction. Should not be given to patients who have received an MAOI within two weeks.

TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention.

Contraindicated in CNS depression and in bone marrow depression.

Suicide is inherent in any depressive illness. Close supervision of patients is essential until satisfactory remission has taken place. This type of patient should not have easy access to large quantities of the drug.

For additional prescribing information, please turn to the following page.

TRIAVIL® 2-25 TRIAVIL® 4-25
TRIAVIL® 2-10 TRIAVIL® 4-10



TABLETS

TRIAVIL®

CONTAINING PERPHENAZINE AND AMITRIPTYLINE HCl
A FLEXIBLE TRANQUILIZER-ANTIDEPRESSANT
FOR MODERATE TO SEVERE ANXIETY WITH DEPRESSION

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TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

CONTAINING PERPHENAZINE AND AMITRIPTYLINE HCl
FOR MANY PATIENTS WITH
MODERATE TO SEVERE ANXIETY WITH DEPRESSION

TRIAVIL® 2-25: Each tablet contains 2 mg of perphenazine and 25 mg of amitriptyline HCl.

TRIAVIL® 2-10: Each tablet contains 2 mg of perphenazine and 10 mg of amitriptyline HCl.

TRIAVIL® 4-25: Each tablet contains 4 mg of perphenazine and 25 mg of amitriptyline HCl.

TRIAVIL® 4-10: Each tablet contains 4 mg of perphenazine and 10 mg of amitriptyline HCl.

INITIAL THERAPY

TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

IN MAINTENANCE THERAPY

TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, narcotics, analgesics, antihistamines) and alcohol; bone marrow depression; pregnancy; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction. Not recommended in children.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, narrow-angle glaucoma, increased ocular pressure, or convulsive disorders. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage.

The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction.

A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant drug. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL has seemed to reduce the likelihood of this effect.

Supervise closely and carefully adjust dosage when given with anticholinergic agents and sympathomimetic drugs.

The drug may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards of therapy. Such treatment should be limited to patients for whom it is essential.

Discontinue several days before elective surgery if possible. Elevation and lowering of blood-sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crises, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reaction); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitivity; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood-sugar levels. **Other:** Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

For more detailed information, consult your MSD Representative or see the Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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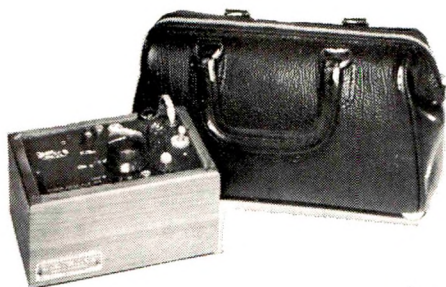
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Other Models Still Available: The CW47, original therapeutic cerebral stimulator with only 3 of the 9 treatment current selections available on Model SOS.

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The goal: A working schizophrenic

Diagnosis: acute schizophrenia. The goals of treatment: Reduction of schizophrenic symptoms; more competent response to environment; the return to productive participation.

Navane (thiothixene) has been found* to be effective in decreasing symptoms of acute or chronic schizophrenia and in increasing levels of functioning. Navane has also been found effective in improving the work output of clinically stable schizophrenic patients.

Patients treated with Navane have shown improvement in work-associated characteristics, such as adaptation to job tasks, response to instructions, concentration and relations with peers and superiors. Of most importance is the improvement Navane-treated patients have shown in overall attitude toward work and productivity.

The schizophrenic patient need not be released from the hospital only to be institutionalized at home. Navane may help him to become a functioning member of his family and a productive member of society.

Navane[®]
(thiothixene) CAPSULES 1 mg., 2 mg., 5 mg., 10 mg.
(thiothixene hydrochloride)
CONCENTRATE 5 mg./cc. — INTRAMUSCULAR 2 mg./cc.

may help the
schizophrenic
patient attain the
goal of productive
participation

ROERIG 

For prescribing information, including adverse reactions and contraindications, please see following page.

*Data available on request.

Navane® (thiothixene) (thiothixene hydrochloride)

Capsules: 1 mg., 2 mg.,
5 mg., 10 mg.

Concentrate: 5 mg./cc.
Intramuscular: 2 mg./cc.

BRIEF SUMMARY

Actions. Navane is a psychotropic agent of the thioxanthene series. Navane possesses certain chemical and pharmacological similarities to the piperazine phenothiazines and differences from the aliphatic group of phenothiazines. Navane's mode of action has not been clearly established.

Indications. Navane is effective in chronically ill schizophrenic patients as well as those with acute schizophrenic manifestations.

The clinical response to Navane is characterized by relief of schizophrenic manifestations such as: hallucinations, hostility, suspiciousness, emotional or social withdrawal, anxiety, agitation, and tension.

Contraindications. Navane is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug.

It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but this possibility should be considered.

Warnings. *Use in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration to rats (5 to 15 mg./kg./day), rabbits (3 to 50 mg./kg./day), and monkeys (1 to 3 mg./kg./day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Use in children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the physical and/or mental abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions. An antiemetic effect was observed in animal studies with Navane; since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura) and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Intramuscular Administration—As with all in-

tramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle.

The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower- and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions. Note: Not all of the following reactions have been reported with Navane. However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur, although it usually subsides with continuation of Navane therapy. The incidence of sedation appears to be similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane. Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

Extrapyramidal symptoms such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Although not reported with Navane, persistent dyskinesias have in rare instances been associated with certain antipsychotic agents. In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, and rare cases of anaphylaxis have been reported with Navane. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecostasia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Note: Sudden deaths have been occasionally reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia

due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration. Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small dosages should be used initially and gradually increased to the optimal effective level, based on patient response.

Usage in children under 12 years of age is not recommended.

Navane Intramuscular Solution—For Intramuscular Use Only. Where more rapid control and treatment of behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg. of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg./day. An oral form should supplement the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane Capsules and Concentrate appear in the following paragraphs.

Navane Capsules; Navane Concentrate—Acute and Chronic Schizophrenic Reactions. In milder conditions, an initial dose of 2 mg. three times daily. If indicated, a subsequent increase to 15 mg./day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg. twice daily.

The usual optimal dose is 20 to 30 mg. daily. If indicated, an increase to 60 mg./day total daily dose is often effective. Exceeding a total daily dose of 60 mg. rarely increases the beneficial response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Overdosage. Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially symptomatic and supportive. For Navane oral, early gastric lavage is helpful. Keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors).

If a vasoconstrictor is needed, levaterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor elevating action of these agents and cause further lowering of blood pressure.

If CNS depression is present, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Picrotoxin or pentylentetrazol should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

How Supplied. Navane (thiothixene) is available as capsules containing 1 mg., 2 mg., 5 mg., and 10 mg. in bottles of 100 and 1,000.

Navane (thiothixene hydrochloride) Concentrate is available in 120 cc. (4 oz.) bottles with an accompanying dropper calibrated at 2 mg., 4 mg., 5 mg., 6 mg., 8 mg. and 10 mg. Each cc. contains thiothixene hydrochloride equivalent to 5 mg. of thiothixene. Contains alcohol, U.S.P. 7.0% v/v. (small loss unavoidable).

Navane (thiothixene hydrochloride) Intramuscular Solution is available in a 2 cc. amber glass vial in packages of 10. Each cc. contains thiothixene hydrochloride equivalent to 2 mg. of thiothixene, dextrose 5% w/v and benzyl alcohol 0.9% w/v.

ROERIG Pfizer
A Division of Pfizer Pharmaceuticals
New York, New York 10017

NOVEMBER 1972

ADVERTISERS INDEX

AYERST LABORATORIES	
Mysoline	188, 189
Premarin	24-28
CHARLES C THOMAS • PUBLISHER	C3
CIBA PHARMACEUTICAL CO. *	
Ritalin	10, 11
Ritalin MBD	176, 177
DEVEREUX FOUNDATION	C4
DOW PHARMACEUTICALS	
Quide	190-192
HARVARD UNIVERSITY PRESS	163
HEALTH SCIENCES PUBLISHING CORP.	167
KNOLL PHARMACEUTICAL	
Akineton	157
LAKESIDE LABORATORIES	
Norpramin	12, 13
LEDERLE	
Artane	32
LITTLE, BROWN AND COMPANY	21
MCNEIL LABORATORIES, INC.	
Haldol	173-175
MERCK SHARP & DOHME	
Cogentin	6, 7
Elavil	16, 17
Triavil	178-180
MONTEFIORE HOSPITAL	1
PFIZER INC.	
Sinequan	160-162
ROERIG DIVISION	
Navane	182-184
REUBEN REITER, ScD. INC.	
Electrostimulators	181
ROCHE LABORATORIES	
Dalmane	8, 9
Librium	186, 187
MMPI	171
Noludar	158, 159
Valium	18-20
WILLIAM H. RORER, INC.	
Quaalude	14, 15
SANDOZ	
Mellaril	30, 31
Serentil	164-166
SANITARIUMS AND PRIVATE HOSPITALS	167
SMITH KLINE AND FRENCH LABORATORIES	
Stelazine	22, 23
Stelazine/Thorazine	C2
WYETH LABORATORIES	
Serax	168-170

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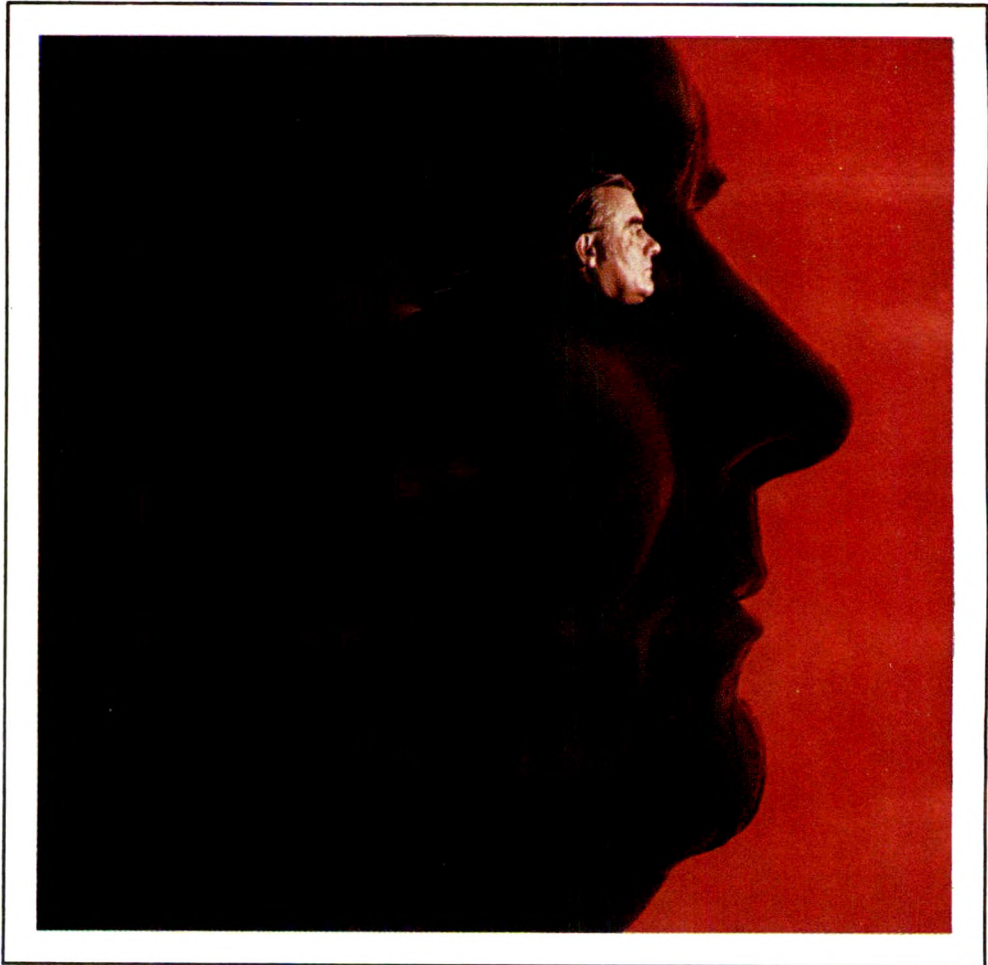
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BASIC ANXIETIES
OF TODAY'S NEUROTIC PATIENT



The Inadequate Self

Low Self-Esteem... High Levels of Anxiety

When the neurotic patient thinks of himself—and he tends to be excessively introspective—his thoughts often represent an extreme self-judgment, a condemning of himself. Characteristically, the neurotic is controlled by self-defining patterns of thoughts inadequately (or pathologically) developed in childhood. (In many cases, his negative self-evaluation stems from the internalization of early parental contempt.) Now, as an adult, he still sees himself as puny, weak, ineffectual, even worthless. Moreover, he lives in a constantly changing, extraordinarily complex and dehumanizing society which, unlike the societies of more stable eras, tends to *deepen* the individual's feelings of inadequacy and helplessness—his inability to cope with stress and to make decisions.

Because the neurotic patient's self-image may be poor, he takes great pains to conceal his presumed inadequacies from others, and their evaluations of his behavior can assume enormous importance. Furthermore, any real, or imagined, disapproval from others tends to induce disproportionately high levels of immobilizing anxiety.

In such cases, the neurotic patient may find himself in a peculiar kind of trap: severe anxiety—with its handicapping effect on both performance and concentration—may reinforce his sense of inadequacy and thus help perpetuate his already ingrained, habitual low self-esteem.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement,

stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

Librium (chlordiazepoxide HCl) In Today's Psychiatric Practice

In many such cases—when the patient's anxiety is, in the therapist's opinion, severely distressing and disabling—Librium (chlordiazepoxide HCl) often becomes a highly useful adjunct to psychotherapy. A dependable, effective antianxiety agent, Librium generally helps keep the neurotic patient's anxiety at tolerable levels, until such medication is no longer required. In addition, the calming influence of Librium may help the patient remain significantly less tense and apprehensive *between* counseling sessions—and may thus help to restore effective performance. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium®
(chlordiazepoxide HCl)
10-mg, 25-mg capsules
up to 100 mg daily in
severe anxiety

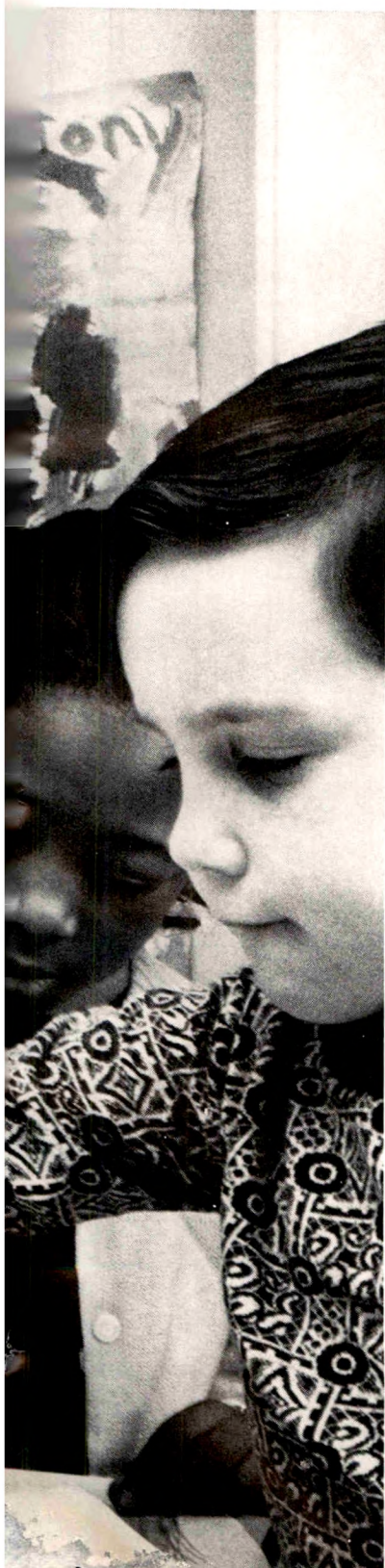


Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Michael was started on
MYSOLINE...kept on it
Brand of PRIMIDONE



...and now, who would know he's an epileptic



When your anticonvulsant regimen only partially controls epileptic symptoms, the concomitant use of MYSOLINE (primidone) in appropriate cases may help you achieve your ultimate therapeutic objective—to bring patients back to normal patterns of living.

The use of MYSOLINE to control seizures when other agents have failed is often possible. Its value in grand mal and focal seizures is well recognized. Furthermore, MYSOLINE has been described as an excellent drug in the treatment of psychomotor seizures.*

Early side effects with MYSOLINE such as ataxia and vertigo are usually transient, and tend to disappear with continued therapy or dosage reduction. MYSOLINE, used either alone or added to other agents, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. Consider it for epileptics in your practice... to help them lead normal lives.

*Millichap, J.G.: Drug therapy and management of the child with epilepsy, *Drug Therapy* 1:15 (Oct.) 1971.

MYSOLINE® (primidone) used alone...used with others... used when others fail

BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE (primidone) Anticonvulsant

INDICATIONS: MYSOLINE, either alone or in combination, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, routine laboratory tests are indicated at regular intervals.

Use in pregnancy: The effect of primidone on the human fetus has not been studied, and the benefit of administration of any drug during pregnancy must be weighed against any possible effect on the fetus.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking MYSOLINE and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K₁ therapy for one month prior to, and during, delivery.

In nursing mothers: There is evidence that in mothers treated with MYSOLINE, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE (primidone)-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. On rare occasion, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	2nd Week 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	4th Week 250 mg. q.i.d.

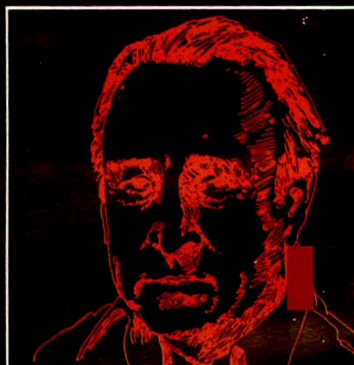
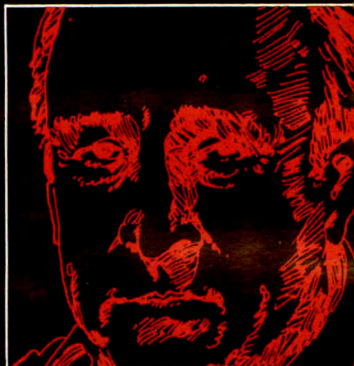
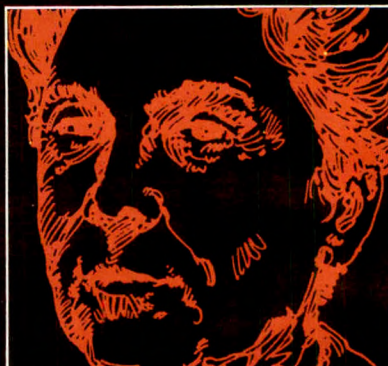
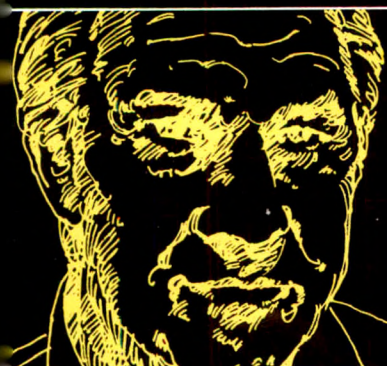
In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE (primidone) should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances: for initiation of combination therapy; during "transfer" therapy; for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.).

HOW SUPPLIED: MYSOLINE Tablets—No. 430—Each tablet contains 0.25 Gm. (250 mg.) of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE Suspension—No. 3850—Each 5 cc. (teaspoonful) contains 0.25 Gm. (250 mg.) of primidone, in bottles of 8 fluidounces.

Ayerst AYERST LABORATORIES
New York, N.Y. 10017



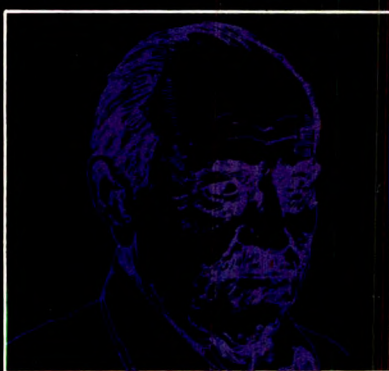
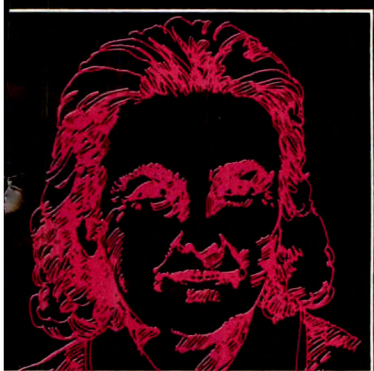
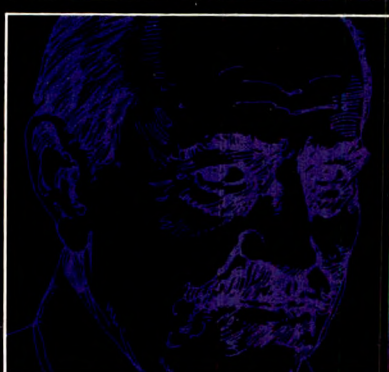
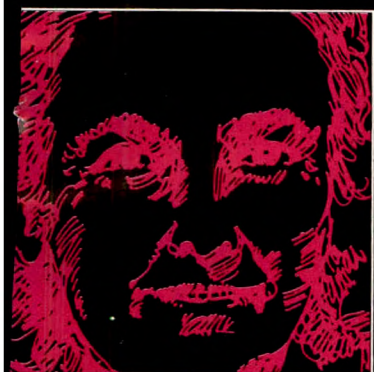
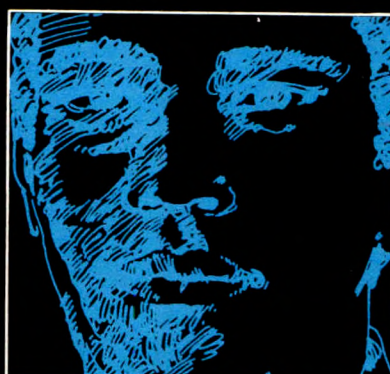
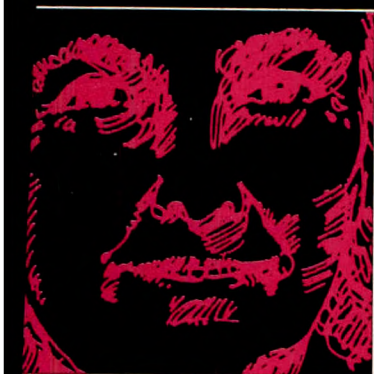
Another phenothiazine—

Maybe you do. Especially if any of your schizophrenic patients are unresponsive to or intolerant of presently available antipsychotic drugs. You know from your own clinical experience that many such patients can benefit only from one drug. They're inaccessible until you find the one that's right for them.

With this fact in mind, we'd like to introduce QUIDE (piperacetazine) to you. This piperidine derivative of phenothiazine has proven anti-

psychotic properties and a clear potential for helping schizophrenics. You and your patients have everything to gain by trying it . . . whether as initial therapy or in cases not responding to current medication.

QUIDE has been subjected to intensive clinical evaluation in both acute and chronic schizophrenic states, and has proved effective in a variety of schizophrenic conditions. Studies reflect moderate to excellent improvement in mental status; but



who needs it?

as with any antipsychotic, not in every patient. Although side effects such as extrapyramidal reactions and oversedation occasionally occurred, dosage modification, or in some cases the addition of an anti-parkinson agent, was helpful in controlling such reactions. QUIDE is regarded as generally well-tolerated . . . an important factor in gaining patient cooperation. No doubt there are schizophrenics who are still waiting for their phenothiazine. If it's QUIDE, we

want you and your patients to know about it.

QUIDE[®] tablets
PIPERACETAZINE



10 mg.
tablets



25 mg.
tablets



DOW PHARMACEUTICALS

The Dow Chemical Company
Indianapolis, Indiana

See next page for complete prescribing information.

13 MAR 1973

QUIDE[®] tablets

PIPERACETAZINE

DESCRIPTION: QUIDE (piperacetazine) is a piperidine derivative of phenothiazine. Piperacetazine has the following chemical designation: 10-(3-[4-(2-Hydroxyethyl)-piperidino] propyl) phenothiazin-2-yl Methyl Ketone.

ACTIONS: The exact mode of action of the phenothiazines is unclear, but drugs of this class produce changes at all levels of the central nervous system, as well as on multiple organ systems.

INDICATIONS: QUIDE is indicated for use in the management of the manifestations of psychotic disorders.

CONTRAINDICATIONS: QUIDE is contraindicated in patients who are comatose or markedly depressed from any cause and in the presence of preexisting thrombocytopenia and other blood dyscrasias, bone marrow depression and in patients with significant liver disease. QUIDE is contraindicated in women who are or may become pregnant since animal reproductive studies adequate to establish safety during pregnancy have not been carried out. QUIDE is contraindicated in patients who have shown hypersensitivity to the drug. Cross sensitivity between phenothiazine derivatives may occur.

WARNING: Like other phenothiazines, QUIDE may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, patients should be cautioned accordingly. Concomitant use with alcohol should be avoided due to the potential additive effect. Patients with known suicidal tendencies should not be given QUIDE except under strict medical supervision.

Use in Children: The use of QUIDE in children under 12 years of age is not recommended because safe conditions for its use have not been established.

PRECAUTIONS: Use with caution in persons who:

1. are receiving barbiturates or narcotics, because of additive effects on central nervous system depression. The dosage of the narcotic or barbiturate should be reduced when given concomitantly with QUIDE (piperacetazine).
2. are receiving atropine or related drugs, because of additive anti-cholinergic effects.
3. have a history of epilepsy, because this drug may lower the convulsive threshold. Adequate anti-convulsant therapy must be maintained concomitantly.
4. are exposed to extreme heat or phosphorous insecticides.
5. have a history of peptic ulcer. Aggravation of pre-existing ulcer has occurred.
6. have cardiovascular disease.
7. have respiratory impairment due to acute pulmonary infections or chronic respiratory disorders such as severe asthma or emphysema.

Keep in mind that the antiemetic effect may mask the toxicity of other drugs or obscure the diagnosis of such conditions as intestinal obstruction or brain tumor. Any sign of blood dyscrasias requires immediate discontinuance of the drug and the institution of appropriate therapy.

The possibility of liver damage, pigmentary retinopathy, lenticular or corneal deposits, and development of irreversible dyskinesias should be kept in mind when patients are on prolonged therapy.

Abrupt Withdrawal: In general, phenothiazines do not produce psychic dependence, but gastritis, nausea and vomiting, dizziness and tremulousness have been reported following abrupt cessation of high-dose therapy. Reports suggest that these symptoms can be reduced if concomitant antiparkinson agents are continued for several weeks after the phenothiazine is withdrawn.

ADVERSE REACTIONS: Not all of the following adverse reactions have been reported with QUIDE, but pharmacological similarities among various phenothiazine derivatives require that each be considered.

Note: Sudden Death has occasionally been reported in patients who have received phenothiazines. In some cases death was apparently due to cardiac arrest, in others the cause appeared to be asphyxia due to failure of the cough reflex. In some patients the cause could not be determined, nor could it be established that death was due to the phenothiazine.

Drowsiness: May occur particularly during the first or second week, after which it generally disappears. If troublesome, lower the dosage.

Jaundice: Incidence is low. When it occurs (usually between the second and fourth weeks of therapy) it is generally regarded as a sensitivity reaction. The clinical picture resembles infectious hepatitis with laboratory features of obstructive jaundice. It is usually reversible although chronic jaundice has been reported with phenothiazine therapy.

Hematological Disorders: Agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenia, purpura and pancytopenia.

Agranulocytosis: Most cases have occurred between the fourth and tenth weeks of therapy. Patients should be watched closely during that period for the sudden appearance of sore throat or other signs of infection. If white blood count and differential show significant cellular depression, discontinue the drug and start appropriate therapy. A slightly lowered white count, however, is not in itself an indication to discontinue the drug.

Cardiovascular: Postural hypotension, tachycardia (especially following rapid increase in dosage), bradycardia, cardiac arrest, faintness and dizziness. Occasionally the hypotensive effect may produce a shock-like condition. In the event a vasoconstrictor is required, levarterenol and phenylephrine are the most suitable. Other pressor agents, including epinephrine, should not be used because a paradoxical further lowering of the blood pressure may ensue. EKG changes, nonspecific, usually reversible, have been observed in some patients receiving phenothiazine tranquilizers. Their relationship to myocardial damage has not been confirmed.

CNS Effects: Neuromuscular (extrapyramidal)

Reactions: These are usually dose related and take three forms: (1) pseudoparkinsonism; (2) akathisia; and (3) dystonias (Dystonias include spasms of the neck muscles, extensor rigidity of back muscles, carpopedal spasm, eyes rolled back, convulsions, trismus and swallowing difficulties). These resemble serious neurological disorders but usually subside within 48 hours. Management of the extrapyramidal symptoms, depending upon the type and severity, includes sedation, injectable diphenhydramine, and the use of antiparkinsonism agents. In rare instances, persistent dyskinesias, usually involving the face, tongue and jaw, have been reported to last months, even years, particularly in elderly patients with previous brain damage. Hyperreflexia has been reported in the newborn when a phenothiazine was used during pregnancy.

Other CNS Effects: Cerebral edema. Abnormality of cerebral spinal fluid proteins. Convulsive seizures, particularly in patients with EEG abnormalities or a history of such disorders. Hyperpyrexia.

Adverse Behavioral Effects: Paradoxical exacerbation of psychotic symptoms.

Allergic Reactions: Urticaria, itching, erythema, photo sensitivity (avoid undue exposure to the sun), eczema. Severe reactions include: exfoliative dermatitis (rare); contact dermatitis in nursing personnel administering the drug; asthma; laryngeal edema; angioneurotic edema; and anaphylactoid reactions.

Endocrine Disorders: Lactation and moderate breast engorgement in females and gynecomastia in males on large doses; changes in libido; false-positive pregnancy tests; amenorrhea; hyperglycemia, hypoglycemia, glycosuria.

Autonomic Reactions: Dry mouth, nasal congestion, constipation, adynamic ileus, myosis, mydriasis, urinary retention.

Special Considerations in Long-term Therapy: After prolonged administration of phenothiazines, pigmentation of the skin has occurred chiefly in the exposed areas, especially in females on large doses. Ocular changes consisting of deposition of fine particulate matter in the cornea and lens, progressing in more severe cases to star-shaped lenticular opacities; epithelial keratopathies; pigmentary retinopathy.

Other Adverse Reactions: Increases in appetite and weight; peripheral edema.

DOSAGE AND ADMINISTRATION: Dosage should be individualized, not only initially but during the course of therapy, and the minimal effective dose should always be employed. A starting dosage of 10 mg two to four times daily is recommended for adults. The dose may be increased up to 160 mg daily within a three to five day period. Should side effects occur, dosage should be reduced or discontinued as indicated. For maintenance therapy, up to 160 mg daily in divided doses may be given.

OVERDOSAGE WITH PHENOTHIAZINES:

Manifestations: One of three clinical pictures may be seen.

1. Extreme somnolence; patient can usually be roused with prodding, but if permitted will fall asleep. General condition is usually satisfactory. The skin, though pale, is warm and dry. Slight blood pressure, respiratory and pulse changes may occur but are not problems.
2. Mild to moderate drop in blood pressure (patient may be conscious or unconscious). Skin is markedly gray but warm and dry. Nail beds are pink. Respiration is slow and regular. Pulse is strong but rate slightly increased.
3. Severe hypotension, possibly accompanied by weakness, cyanosis, perspiration, rapid, thready pulse and respiratory depression.

Treatment: Is essentially symptomatic and supportive. Early gastric lavage and intestinal purges may help. Centrally acting emetics may not help because of the possible antiemetic effect of QUIDE (piperacetazine). Give hot tea or coffee. Severe hypotension usually responds to measures described under hypotensive effects (see ADVERSE REACTIONS: Cardiovascular). Additional measures include pressure bandages to lower limbs, oxygen and I.V. fluids. Avoid stimulants that may cause convulsions (e.g., picrotoxin and pentylene-tetrazolol). Limited experience with dialysis indicates that it is not helpful.

CAUTION: Federal law prohibits dispensing without prescription.

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December 1972

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Crisis Intervention

Official Journal of the American Psychiatric Association



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INNOVATIONS IN HELPING CHRONIC PATIENTS

College Students in a Mental Institution

by **JULIAN RAPPAPORT**, Department of Psychology, Univ. of Illinois, Urban-Champaign, Ill., **JACK M. CHINSKY**, Department of Psychology, Univ. of Connecticut, Storrs, and **EMORY L. COWEN**, Department of Psychology, Univ. of Rochester, N.Y.

This book describes an experimental program based on the fundamental principle of the community mental health movement—"the helper-therapy principle." The program used college students as group leaders to help in the treatment of chronic hospitalized patients. In a research perspective, the book deals with three focal issues. First is the general problem of institutional innovation—the attempt to mobilize an entrenched custodially oriented institution toward viable new programs. Second is the specific problem of finding effective techniques for treating chronic mental patients. Finally, there is the question of involving college students in meaningful, "real-world" roles. The book opens with a brief review of both traditional care for chronic mental patients and of other projects using nonprofessionals, followed by an analysis of the problems of large mental hospitals. It then describes the design, methodology, and outcome of the student program, and closes with a detailed description of the clinical, experimental, and human aspects of the program as seen through the eyes of the students, the patients, and the authors. 1971, 204 pp., \$8.00

THE NEW HOSPITAL PSYCHIATRY

Proceedings of an Interdisciplinary Conference Sponsored by The University of Wisconsin Psychiatric Institute, June 5-7, 1969

edited by **GENE M. ABROMS**, Associate Professor of Psychiatry, Univ. of Wisconsin Medical School, Madison, and **NORMAN S. GREENFIELD**, Professor of Psychiatry, Associate Director, Wisconsin Psychiatric Inst., Univ. of Wisconsin Medical Center, Madison

Psychiatric hospitals have been criticized in recent years on a number of counts: administrative rigidity and formalism, poor staff training, imposing passivity (and even deviancy) on their patients, and especially treating patients outside of the context of their lives in society. This book is partly the result of these criticisms and partly the answer to them. It presents new therapeutic techniques that embrace individual and group therapy, psychoactive drugs, behavioral learning approaches, intensive couple and family therapy, psychodrama, and role playing. These techniques approach mental disturbances not only as biological-medical problems to be treated as diseases, but also as sociological-behavioral difficulties to be attacked by teaching the patient to improve his psychosocial and behavioral skills. In addition to new forms of training within the hospital, the book recommends a new social role for the hospital itself, a role which takes the hospital staff into the community—to the addicts, the ghetto, and the suburbs—wherever home and community neighborhood therapy can be instituted. 1971, 308 pp., \$10.00

ANXIETY

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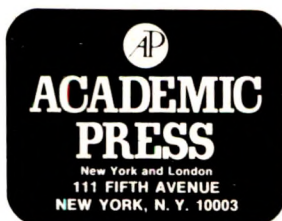
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A TWIN STUDY VANTAGE POINT

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CONTENTS: December 1972

Volume 129, Number 6

Why Men Seek Psychotherapy: I. Results of a Survey of College Graduates <i>E. Vaillant</i>	George	645
1972 Anniversaries	<i>George Mora</i>	652
The Pseudo-Regulation of American Psychiatry	<i>Robert L. Taylor and E. Fuller Torrey</i>	658
A Commentary on "The Pseudo-Regulation of American Psychiatry"	<i>Shervert H. Frazier</i>	664
Group Drinking During Stress: Effects on Drinking Behavior, Affect, and Psychopathology	<i>Lawrence R. Allman, H. Augustus Taylor, and Peter E. Nathan</i>	669
Depression During Mania: Clinical Observations and Theoretical Implications	<i>Joel Kolin and Frederick K. Goodwin</i>	679
Family Noncommunication: The Search for Kidney Donors	<i>Robert G. Simmons and Susan D. Klein</i>	687
Comparing MMPI Statements and Mental Status Items	<i>Donald W. Morgan, William D. Weitzel, Thomas E. Guyden, James A. Robinson, and James L. Hedlund</i>	693

Change of Command in Combat: A Locus of Stress	<i>Douglas R. Bey, Jr.</i>	698
A Comparison of Amok and Other Homicide in Laos	<i>Joseph Westermeyer</i>	703

SPECIAL SECTION

Crisis Intervention

Community Psychiatry and Emergency Service	<i>Donald A. Schwartz, Audrey T. Weiss, and James M. Miner</i>	710
Rehospitalization Versus Family Crisis Intervention	<i>David Rubinstein</i>	715
Pediatric Hospitalization as Crisis Intervention	<i>Richard Galdston and Michael C. Hughes</i>	721
Crisis Intervention and Prevention of Psychiatric Disability: A Follow-Up Study	<i>J. Barry Decker and J.M. Stubblebine</i>	725
Hotlines and Youth Culture Values	<i>Paul Torop and Karen Torop</i>	730

DEPARTMENTS

EDITOR'S NOTEBOOK

Crisis Intervention	<i>Donald G. Langsley</i>	734
Changes in the Offing	<i>F.J.B.</i>	736

BRIEF COMMUNICATIONS

Aberrant Response to Diazepam: A New Syndrome	<i>Richard C.W. Hall and Joy R. Joffe</i>	738
The Importance of Psychiatrists' Telling Patients the Truth	<i>William S. Appleton</i>	742
Sex, Age, and the Diagnosis of Hysteria (Briquet's Syndrome)	<i>Samuel B. Guze, Robert A. Woodruff, Jr., and Paula J. Clayton</i>	745
Psychotherapy by Counter-Manipulation	<i>James M. Krainin</i>	749
Drug Flashbacks: Reported Frequency in a Military Population	<i>M. Duncan Stanton and Alexander Bardoni</i>	751
The Psychology of Hallucinogenic Drug Discontinuers	<i>Carl Salzman, Jonathan Lieff, Gerald E. Kochansky, and Richard I. Shader</i>	755

IN MEMORIAM

Thomas J. Heldt, 1883-1972	<i>John M. Dorsey</i>	762
Austin M. Davies, 1900-1972	<i>F.J.B.</i>	763

LETTERS TO THE EDITOR

765

BOOK REVIEWS

770

ANNUAL INDEX

Author Index	780
Subject Index	786



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2. Schildkraut JJ: Tranlycypromine: effects on norepinephrine metabolism in rat brain. *Amer J Psychiat* 126: 925-931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interactions between monoamine oxidase inhibitors and foodstuffs. *Brit J Psychiat* 113: 349-365, 1967

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Antilirium (Physostigmine Salicylate) stops delirium caused by atropine or scopolamine

In a study by Dr. Roger C. Duvoisin and Dr. Ronald Katz, reported in JAMA Vol 206, #9, November 25, 1968, physostigmine salicylate was found to be an effective antidote to intoxication caused by centrally active anticholinergic agents.

Dr. Duvoisin and Dr. Katz summarized their study as follows: "Physostigmine salicylate in doses of 1 to 2 mg. administered parenterally was found to be an effective antidote to intoxication with centrally active anticholinergic agents. Confusion, agitation, hallucinations, stupor, ataxia, dysarthria, and other symptoms were promptly reversed in 26 consecutive patients in whom toxic reactions developed after receiving scopolamine, atropine, or drugs for Parkinson's disease. Physostigmine deserves a place in therapeutics as an antidote to anticholinergic intoxications."

A study conducted by Dr. L. T. Greene of the Department of Anesthesiology, College of Physicians and Surgeons, Columbia University and the Columbia-Presbyterian Medical Center, New York, New York, entitled "Physostigmine Treatment of Anticholinergic Drug Depression in Post-operative Patients" appears on page 222 of the March-April 1971 edition of "Anesthesia & Analgesia".

Dr. Greene describes the results of physostigmine salicylate regarding one of the patients in the study as follows: "The patient had been hallucinating vividly for several hours before receiving physostigmine salicylate intramuscularly; she became rational within one-half hour of the injection"

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WARNING: If excessive sweating, nausea, or vomiting occur, reduce dosage.

PRECAUTIONS: Because of the possibility of hypersensitivity in an occasional patient, atropine sulfate injection should always be at hand since it is an antagonist and antidote for physostigmine.

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In the course of a four-week trial,** the investigator studied the effects of Valium (diazepam) in 21 psychoneurotic patients, all with marked anxiety and tension and most with associated depressive symptoms. The Valium daily dosage was 15 mg in divided doses, throughout, except for two patients who required a doubling of daily dosage (30 mg). The medication supplemented psychotherapy.

The clinician rated patients' behavior on a modified Brief Psychiatric Rating Scale* before, during, and at the end of treatment. From the individual symptom ratings and the physician's global assessment, it appeared that the concomitant use of Valium and psychotherapy effectively reduced the severity of the anxiety and tension in most patients.

The BPRS itself, it should be observed, was employed as a measure of response to therapy. It is not intended to, nor can it, suggest indications for specific medication.

Of the 21 patients in the group at the outset, four discontinued treatment some time after the second week because of side effects. Eight patients, including the four who stopped medication, reported one or more side effects: 1 constipation; 7 drowsiness/sleepiness; 1 dry mouth; 3 fatigue/exhaustion; 1 gastrointestinal disturbance; 1 insomnia; 2 nervousness/jitteriness/restlessness; 1 nightmares; 1 unpleasant dreams; 1 vertigo.

The patients studied are probably fairly typical of many of your outpatients with marked psychoneuroses. And from the clinical evidence reported over the past nine years, the response to the concomitant use of Valium and psychotherapy seen in this study would also appear to be typical. Valium's beneficial effects can be prompt and pronounced. In recommended dosage, it seldom dulls the senses or interferes with regular activities, although you should caution patients against driving or operating dangerous machinery during therapy. Valium is generally well tolerated: the most common side effects have been drowsiness, ataxia and fatigue.

For individualized treatment, three convenient tablet strengths are available: 2 mg, 5 mg and 10 mg.

*Adapted from the Brief Psychiatric Rating Scale by Overall and Gorham. Nine symptoms deemed inappropriate to this study of anxious psychoneurotic patients were omitted from the original scale.

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Here's what a group of anxious psychoneurotics

(most with associated depressive symptoms)

looked like

after Valium® (diazepam) and psychotherapy

Pretreatment evaluations were compared with those of the second and fourth week of treatment, yielding a cumulative "improvement" score for each patient, symptom and observation interval.† A global assessment of the patient's emotional status was also made at each rating period.

Psychiatric Evaluation on a Modified BPRS*	Average scores of 17 patients—out of initial group of 21 patients—in study for 26 or more days**				
	Not present	Very mild/ mild	Mod- erate	Moder- ately severe/ severe	Extremely severe
1. Somatic concern	1	2	3	4	5
2. Anxiety	1	2	3	4	5
3. Emotional withdrawal	1	2	3	4	5
4. Guilt feelings	1	2	3	4	5
5. Tension	1	2	3	4	5
6. Depressive mood	1	2	3	4	5
7. Hostility	1	2	3	4	5
8. Motor retardation	1	2	3	4	5
9. Blunted affect	1	2	3	4	5

†With the exception of excessive anxiety and undue tension, the signs and symptoms shown in the Modified BPRS are not in themselves indications for Valium.

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Description: Valium (diazepam) is a benzodiazepine derivative developed through original Roche research. Chemically, diazepam is 7-chloro-1,3-dihydro-1-methyl-5-phenyl-2H-1,4-benzodiazepin-2-one. It is a colorless, crystalline compound, insoluble in water and has a molecular weight of 284.74.

Pharmacology: In animals Valium (diazepam) appears to act on parts of the limbic system, the thalamus and hypothalamus, and induces calming effects. Valium (diazepam), unlike chlorpromazine and reserpine, has no demonstrable peripheral autonomic blocking action, nor does it produce extrapyramidal side effects; however, animals treated with Valium (diazepam) do have a transient ataxia at higher doses. Valium (diazepam) was found to have transient cardiovascular depressor effects in dogs. Long-term experiments in rats revealed no disturbances of endocrine function.

Oral LD₅₀ of diazepam is 720 mg/kg in mice and 1240 mg/kg in rats. Intraperitoneal administration of 400 mg/kg to a monkey resulted in death on the sixth day.

Reproduction Studies: A series of rat reproduction studies was performed with diazepam in oral doses of 1, 10, 80 and 100 mg/kg. At 100 mg/kg there was a decrease in the number of pregnancies and surviving offspring in these rats. Neonatal survival of rats at doses lower than 100 mg/kg was within normal limits. Several neonates in these rat-reproduction studies showed skeletal or other defects. Further studies in rats at doses up to and including 80 mg/kg/day did not reveal teratological effects on the offspring.

In humans, measurable blood levels of Valium (diazepam) were obtained in maternal and cord blood, indicating placental transfer of the drug.

Indications: Valium (diazepam) is useful in the symptomatic relief of tension and anxiety states resulting from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation.

In acute alcohol withdrawal, Valium (diazepam) may be useful in the symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis.

Valium (diazepam) is a useful adjunct for the relief of skeletal muscle spasm due to reflex spasm to local pathology (such as inflammation of the muscles or joints, or secondary to trauma); spasticity caused by upper motor neuron disorders (such as cerebral palsy and paraplegia); athetosis; and stiff-man syndrome.

Oral Valium (diazepam) may be used adjunctively in convulsive disorders, although it has not proved useful as the sole therapy.

Contraindications: Valium (diazepam) is contraindicated in patients with a known hypersensitivity to this drug and, because of lack of sufficient clinical experience, in children under 6 months of age. It may be used in patients with open angle glaucoma who are receiving appropriate therapy, but it is contraindicated in acute narrow angle glaucoma.

Warnings: Valium (diazepam) is not of value in the treatment of psychotic patients and should not be employed in lieu of appropriate treatment. As is true of most preparations containing CNS-acting drugs, patients receiving Valium (diazepam) should be cautioned against engaging in hazardous occupations requiring complete mental alertness such as operating machinery or driving a motor vehicle.

As with other agents which have anticonvulsant activity, when Valium (diazepam) is used as an adjunct in treating convulsive disorders, the possibility of an increase in the frequency and/or severity of grand mal seizures may require an increase in the dosage of standard anticonvulsant medication. Abrupt withdrawal of Valium (diazepam) in such cases may also be associated with a temporary increase in the frequency and/or severity of seizures.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other CNS-depressant drugs during Valium (diazepam) therapy.

Physical and Psychological Dependence: Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of diazepam (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). These were usually limited to those patients who had received excessive doses over an extended period of time. Particularly addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving diazepam or other psychotropic agents because of the predisposition of such patients to habituation and dependence.

Use in Pregnancy: Use of any drug in pregnancy, lactating or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to mother and child. (See *Reproduction Studies*.)

Management of Overdosage: Manifestations of Valium (diazepam) overdosage include somnolence, confusion, coma and diminished reflexes. Respiration, pulse and blood pressure should be monitored, as in all cases of drug overdosage, although, in general, these effects have been minimal following overdosage. General supportive measures should be employed, along with immediate gastric lavage. Intravenous fluids should be administered and an adequate airway maintained. Hypotension may be combated by the use of Levophed® (levarterenol) or Aramine (metaraminol). Ritalin (methylphenidate) or caffeine and sodium benzoate may be given to combat CNS-depressive effects. Dialysis of limited value. As with the management of intentional overdosage with any drug, it should be borne in mind that multiple agents may have been ingested.

Precautions: If Valium (diazepam) is to be combined with other psychotropic agents or anticonvulsant drugs, careful consideration should be given to the pharmacology of the agents to be employed—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. The usual precautions are indicated for severely depressed patients or those in whom there is any evidence of latent depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

In elderly and debilitated patients, it is recommended that the dosage be limited to the smallest effective amount to preclude the development of ataxia or oversedation (2 mg to 2½ mg once or twice daily, initially, to be increased gradually as needed and tolerated).

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue and ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued.

Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

Dosage and Administration: Dosage should be individualized for maximum beneficial effect. While the usual daily dosages given below will meet the needs of most patients, there will be some who may require higher doses. In such cases dosage should be increased cautiously to avoid adverse effects.

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Adjunctively in Convulsive Disorders.

Geriatric Patients, or in the presence of debilitating disease.

Children:

Because of varied responses to CNS-acting drugs, initiate therapy with lowest dose and increase as required. Not for use in children under 6 months.

How Supplied: For oral administration: Valium (diazepam) scored tablets—2 mg, white; 5 mg, yellow; and 10 mg, blue—bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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2 mg to 10 mg, 3 or 4 times daily

2 mg to 10 mg, 2 to 4 times daily

2 mg to 2½ mg, 1 or 2 times daily initially; increase gradually as needed and tolerated

1 mg to 2½ mg, 3 or 4 times daily initially; increase gradually as needed and tolerated

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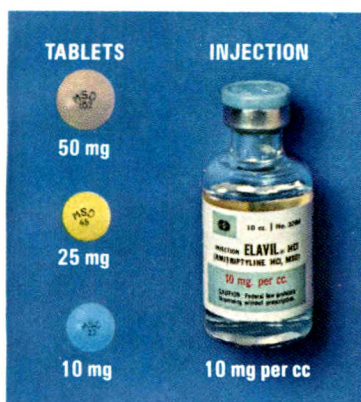
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Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises and deaths have occurred. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established, in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs,

close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns, extrapyramidal symptoms; tinnitus. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. **Other:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

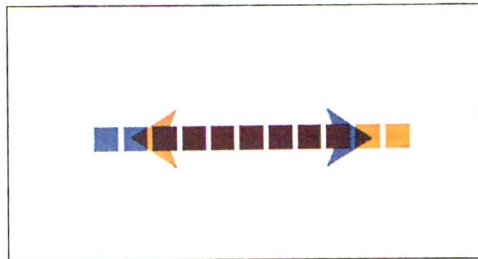
How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 cc.

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permitting psychotherapy to proceed. Librium is prescribed by psychiatrists as adjunctive therapy

in the psychoneurotic patient as sensitive material is probed. In turn, the therapeutic impasse can generate further patient anxiety and tension. In such cases, the reduction of intense anxiety with the help of Librium (chlordiazepoxide HCl) usually facilitates verbal exchange, thereby

because it has been found to make anxiety-blocked patients more amenable to psychotherapy. Moreover, for patients incapacitated by excessive anxiety, the action of Librium (chlordiazepoxide HCl) often favors restored performance.

Many psychiatrists have found that

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of

the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement,

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Librium 25 mg, given *t.i.d.* or *q.i.d.*, is particularly suitable for the relief of severe anxiety. An additional advantage is that,

after more than 12 years of wide clinical use, Librium continues to demonstrate an impressive record of safety. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

Librium® (chlordiazepoxide HCl)



As with all CNS-acting agents, patients receiving Librium should be cautioned against hazardous occupations requiring

complete mental alertness, such as operating machinery or driving a motor vehicle. When excessive anxiety has been reduced to appropriate levels, Librium therapy should be discontinued.

for severe anxiety
Librium® 25 mg
(chlordiazepoxide HCl)
1 capsule *t.i.d./q.i.d.*

stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

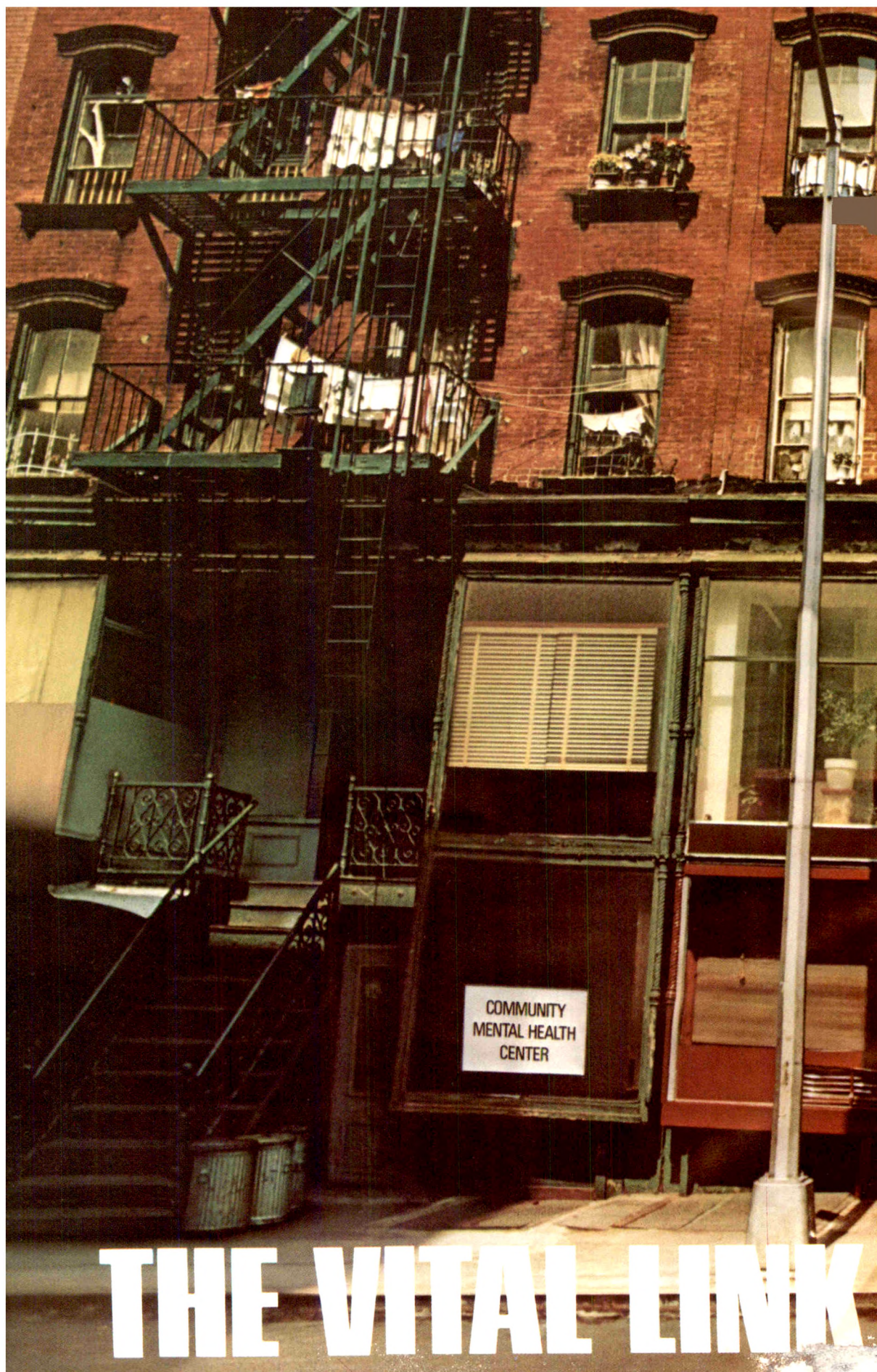
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal

symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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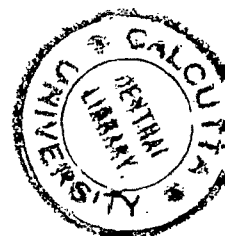


THE VITAL LINK

THE AMERICAN JOURNAL OF PSYCHIATRY

Why Men Seek Psychotherapy: I. Results of a Survey of College Graduates

BY GEORGE E. VAILLANT, M.D.



A questionnaire survey comparing 112 middle-aged men who had made ten or more visits to a psychiatrist with 531 men who did not revealed that occupational failure, never marrying, and heavy alcohol use (all indirect indicators of mental illness) were not correlated with seeking psychotherapy. However, variables reflecting social supports (stable marriage, sports participation, church attendance, etc.) and subjective physical health status (hospitalization, days of sick leave per year, abdominal pain with stress, etc.) were strongly associated with whether men sought psychotherapy. A replication study supported the validity of these findings.

THE DECISION to seek psychiatric care is often independent of the degree of psychiatric disability. The epidemiological investigations of both the Stirling County and the Midtown Manhattan studies have demonstrated that many of those most in need of psychiatric help never seek it, especially if they are poor (1, 2). Conversely, a disproportionate amount of psychiatric care is apparently devoted to individuals who are of high economic status, have graduate degrees, and who reside near large metropolitan centers (3). Their psychiatrists perceive members

of this latter group as ill, but their relative degree of disability goes undetermined.

In order to understand the psychotherapeutic process, it behooves us to identify the kinds of people who seek psychotherapy. This can only be done by the use of adequate control groups. The present study compares 112 men who sought psychotherapy with 531 socioeconomic peers who did not. Since the men were between ages 45 and 50, they had passed beyond the age of maximum utilization of psychotherapy. Virtually all were economically successful, intellectually sophisticated college graduates. Although highly selected and relatively healthy, this group permits the identification of factors associated with psychotherapy that are independent of both the magnitude of psychopathology per se and of psychological sophistication and financial resources.

Method

The source of the information was an anonymous questionnaire mailed to 895 men on the twenty-fifth anniversary of their graduation from a private liberal arts college. Such anonymous questionnaires have been a traditional and serious feature of the reunion. The instructions for the questionnaire, sponsored by the class officers, began:

This year the Anonymous Questionnaire will also be used to provide a comparison group for the "Adult Development Study" in which some of you have taken part. . . . It represents one of the best medically and psychologically studied groups of "normals" in the world. For science, then, as well as to edify yourself and your classmates, the class hopes for a 100 percent return of the Anonymous

Revised version of a paper read at the 124th annual meeting of the American Psychiatric Association, Washington, D.C., May 3-7, 1971.

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Questionnaires and that you will answer all of the questions.

The data for all 55 questions were analyzed by means of correlation matrices, unsimplified contingency tables, multiple regression analysis, and orthogonal varimax factor analysis. However, for the current discussion the clearest and briefest method of data presentation could be achieved by dichotomizing answers to the multiple-choice questions, presenting association in terms of four-cell contingency tables, and using the chi-square test of significance.

Among the 55 questions on the multiple-choice questionnaire were two of special interest to the present report:

1. Have you ever consulted a psychiatrist? Never ____, 1-10 visits ____, 10+ visits ____.

2. When under stress what do you notice about your physical reaction? Headache ____, Insomnia ____, Indigestion or abdominal pain ____, Sweating ____, Frequent colds ____, Smoke and drink more ____, Inability to concentrate ____, Other ____, Honestly nothing ____.

Two items evaluating the men's marriage and work status represented composites of their answers to several questions. "Very stable marriage" meant that the man reported that he had been married only once, that he rated his current marital situation as "quite stable," and that he had stated that divorce or separation had never been even casually considered. "Overall lack of success" meant rating one's career as "not very successful" or "quite unsuccessful" and regarding oneself as "less successful" than one's father when he was the same age.

Results

Seventy-two percent of the 895 questionnaires were returned; only one questionnaire was facetiously answered and grossly invalid. On the average, two questions on each questionnaire were scored as blanks. While the characteristics of the nonrespondents are uncertain, prior experience with this population suggests that the chief reasons for nonresponse were lack of feeling for class membership due to disruption of education by World War II, membership in a profession emphasizing the physical sciences, and current domestic or emotional crises. Thus the sample is

probably skewed to exclude a disproportionate number of the psychiatrically ill and/or the least psychologically minded.

For the purpose of this paper "psychotherapy" is arbitrarily defined as a minimum of ten visits to a psychiatrist. Thus 17 percent of the sample (112 men) obtained psychotherapy. Fourteen percent of the men reported seeing a psychiatrist one to ten times; 69 percent had never sought psychiatric consultation. The social class of the family of origin (defined by private school attendance or by *Social Register* membership) was not correlated with whether a man sought psychotherapy.

Emotional impairment did not appear statistically significant in differentiating those who sought psychotherapy and those who did not. Table 1 shows that occupational success or enjoyment was not associated with having sought psychotherapy; yet the more severe forms of mental illness (psychosis, sociopathy, passive-aggressive character, and so forth) certainly do affect occupational success. Other signs of mental disability—alcoholism (defined as consumption of eight or more ounces of alcohol a day), never marrying, multiple job changes, and falling in the bottom fifth of the class in income (less than \$20,000 a year)—were statistically unassociated with psychotherapy.

Table 1 also shows that marital disharmony was strongly associated with the decision to seek psychotherapy. Intensive study and interview of a subsample from this population confirmed the hypothesis that in this population marital disharmony was causally related to seeking psychotherapy.

Within the limitations of the questionnaire, inability to concentrate under stress seemed the best indirect indicator of psychiatric disability. Men who reported an inability to concentrate under stress were three times more likely to have sought psychotherapy than their classmates and ten times more likely to have sought therapy than those who reported that stress had no physical effect. But inability to concentrate under stress per se was also strongly associated with inferior occupational history ($p < .001$). This association helps to support the assumption that both anxiety and depressive states—characterized by reported inability to concentrate—are associated with impaired occupational success. It is surprising that men who reported *ever* having made ten

TABLE 1
Association of Emotional Ill Health with Psychotherapy

ITEM	PERCENTAGE OF TOTAL SAMPLE (N = 643)	PERCENTAGE SEEKING PSYCHOTHERAPY (10 OR MORE VISITS) (N = 112)	PERCENTAGE UNABLE TO CONCENTRATE WITH STRESS (N = 87)
Work			
"Extremely satisfying" work	55	54	37*
Annual salary of \$40,000 or more	21	18	6*
Overall lack of success	6	7	8
Marriage			
Very stable marriage	55	29*	43
Divorced	12	23*	14
Single	6	7	8
Emotional well-being			
Psychotherapy (10 or more visits)	17	100	41*
Daily consumption of eight or more ounces of alcohol	4	5	1
Frequent use of tranquilizers or sedatives	7	23*	14**
Inability to concentrate with stress	14	32*	100

*Significantly different from the rest of the sample; $p < .001$.

**Significantly different from the rest of the sample; $p < .03$.

or more visits to a psychiatrist were many times more likely to be *currently* receiving psychotropic medications than men who had never seen a psychiatrist.

Table 2 illustrates that subjective physical ill health was strongly associated with psychotherapy. Men who took virtually no sick leave, who described their current health as excellent, and who had not been hospitalized more than once in the last 25 years were only half as likely to have sought psychotherapy as their less robust classmates. Increased colds, abdominal pain, or indigestion under stress (but not headache or increased sweating) were also significantly associated with an increased likelihood of having obtained psychotherapy. Men who reported that stress had no physical effect on them were five times less likely to seek psychotherapy than their classmates. The first six items were strongly inter-correlated and comprise the factor subsequently referred to as subjective ill health.

In sum, the findings in table 2 suggest that

quite independently of the objective signs of psychological impairment (e.g., failure to marry, alcoholism, occupational failure), it is awareness of subjective symptoms of physical and mental distress (e.g., unhappy marriage, insomnia, inability to concentrate) that are associated with psychotherapy. In this population the person whose body functioned without recourse to hospitals or sick leave was the person who experienced less dysphoria from stress and who sought less help from psychiatrists.

Table 3 suggests another group of items that are strongly associated with psychotherapy. If in 1968 a 47-year-old man answered "yes" to five of the items labeled social supports, he was ten times less likely to have sought psychotherapy than if he had answered "yes" to two or fewer. The label social supports was chosen because all of the items suggest that the respondent finds sources of support or satisfaction within his immediate social environment. All of the items labeled

TABLE 2
Association of Physical Ill Health with Psychotherapy

ITEM	PERCENTAGE OF TOTAL SAMPLE (N = 643)	PERCENTAGE SEEKING PSYCHOTHERAPY (10 OR MORE VISITS) (N = 112)	PERCENTAGE UNABLE TO CONCENTRATE WITH STRESS (N = 87)
Current health not "very good" or "excellent"	23	27*	29*
Two or more hospitalizations since college	34	43*	38
Five or more days of sick leave per year	7	16**	8
With stress, more colds	4	9*	4
With stress, stomach pain	24	33*	26
With stress, insomnia	25	38**	29
Stress has no physical effect	16	3**	—

*Significantly different from the rest of the sample; $p < .03$.

**Significantly different from the rest of the sample; $p < .001$.

social supports were strongly associated with each other (usually at the $p < .001$ level).

At first glance the items seem to reflect anti-intellectual, right-wing views. However, the items reflecting marriage, church attendance, and sports participation were not significantly related to reading habits, attitudes toward our Viet Nam involvement, or a right-wing presidential choice. More significantly, all of the items reflecting social supports were associated with not seeking psychotherapy. But in this population of 47-year-old college graduates, the pro-Reagan and the opera-and book-eschewing advocates of military escalation in South Viet Nam sought psychotherapy as frequently as their classmates.

The six individual items describing social supports were not statistically associated with most of the six items describing subjective ill health (table 2). But these latter items were also all strongly associated with psychotherapy and intercorrelated with each other. Social supports were *not* associated with social class.

Table 3 shows that there is an increased tendency for physicians and men who "with stress can't concentrate" (i.e., those who are mentally ill) to obtain psychotherapy. These last two variables are not statistically associated with social supports; multiple regression analysis demonstrated that they played a minor role compared to absence of social supports and subjective ill health in predicting who sought psychotherapy.

Men who enjoyed physical well-being but who lacked social supports and men who experienced subjective ill health but possessed several social supports were three times more likely to have sought psychotherapy than men who enjoyed both physical well-being and several social supports. But a man who experienced both subjective ill health (two or more items from table 2) and had less than four social supports was more than six times as likely to have sought psychotherapy as his more fortunate classmate.

Table 4 further emphasizes that subjective ill health and sparse social supports are independent predictors of whether a person will seek psychotherapy. Every individual was assigned a score from 0 to 12; this score was derived from the sum of items reflecting social supports that were absent and the number of items reflecting subjective ill health that were present. The figure shows that in extreme

TABLE 3
Association of Social Supports and Other Variables with Psychotherapy

ITEM	PERCENTAGE SEEKING PSYCHOTHERAPY	
	0-10 VISITS (N = 529)	10 OR MORE VISITS (N = 112)
Social support		
Regular church attendance	41	19*
Very stable marriage	60	29*
Frequent participation in competitive sports	32	17**
Conservative leanings	32	12**
Wants less government control of the individual	76	56*
Not overtly pro hippies and student activists	93	80*
Miscellaneous variables		
Reads 12 or more books per year	33	38
Attends seven or more concerts or operas per year	12	18
Wants no reduction in Viet Nam involvement (1967-1968)	20	16
Favored Johnson, Reagan, or Wallace in 1968	5	4
Physician	11	27*
With stress, cannot concentrate	10	32*

*Significantly different; $p < .001$.

**Significantly different; $p < .05$.

cases this information alone was enough to predict whether an individual had ever sought psychotherapy. None of the 27 men with a score of 0 and 70 percent of the 26 men with a score of 7 or more had seen a psychiatrist ten or more times.

Since all 12 of the predictive items were chosen for analysis *ex post facto* because of their statistical association with psychotherapy, demonstration of predictive power required confirmation in a fresh sample. Fortunately, I was able to test another sample of 113 socioeconomically similar men, in whom all the variables under study (except how they felt regarding the role of government in the life of the individual) were available (4, 5).

Table 5 provides the results of using the available 11 items to predict whether these men had sought psychotherapy in the past 30 years. The likelihood of their having sought psychotherapy increased dramatically with the number of predictive items present. Almost everyone who scored seven or more items had seen a psychiatrist; almost no one

TABLE 4
Percentage of Men Seeking Psychotherapy Who Had a Given Number of Predictor Items

NUMBER OF PSYCHIATRIC VISITS	ITEM SCORE								
	0 (N = 27)	1 (N = 75)	2 (N = 135)	3 (N = 130)	4 (N = 127)	5 (N = 78)	6 (N = 42)	7 (N = 21)	8 (N = 5)
None	89	87	84	72	61	53	38	24	20
One-ten	11	10	9	15	16	21	26	9	—
Ten or more	0	3	7	13	23	26	36	67	80

scoring two or fewer items had ever seen a psychiatrist. (Unpublished data showed that the sum of these 11 items correlated more highly with the subjects' having sought psychotherapy than with whether they were diagnosed as psychiatrically ill.)

Multiple regression analysis confirmed the impression that no single item accounted for the largest part of the statistical variance in predicting use of psychotherapy. Both the cluster of items reflecting social supports and the cluster reflecting subjective ill health contributed an equal amount of variance (ten to 11 percent) in accounting for the number of psychiatric visits.

Discussion

The results of this study confirm evidence well summarized by Kadushin that the rich, the educated, and the comparatively healthy seek and obtain a disproportionate share of psychotherapists' time (3). There is not adequate psychiatric manpower to offer the adult population of the United States the degree of psychiatric care obtained by these relatively healthy men.

The study also suggests a less widely appreciated fact: The person who visits a psychiatrist has much in common with the person who often visits his general practitioner or who is referred by the medical specialist to the hospital social worker. Such a person experiences subjective ill health and tends to lack social supports, yet not infrequently he may be free

of incapacitating emotional illness. This finding lends support to the principle that those who conduct psychotherapy should have medical training or be under the supervision of a physician. Emotional and physical distress are inextricably entwined.

Studies of outpatient psychiatric clinics have suggested that the uneducated and lower classes somatize or take pills and that the educated upper classes seek psychotherapy (3, 6). But such studies have not used peer groups for comparison. In this population with a median income of over \$25,000 a year and in which 70 percent had attended graduate school, pill taking was clearly correlated with the tendency to seek psychotherapy. Men who had ever had psychotherapy currently used sleeping pills and tranquilizers ten times more often than did men who had never visited a psychiatrist.

During World War II Star and associates developed the Army Neuropsychiatric Screening Adjunct (NSA) (7). Its items included queries about fainting spells, frequent palpitations, frequent headaches, frequent dizziness, cold sweats, sick headaches, physical health problems, and insomnia. The NSA physical symptom items predicted rejection on psychiatric grounds better than did scales reflecting personal adjustment, childhood neurotic symptoms, or child-parent relationships. The NSA items were also heavily associated with psychiatric "caseness" in the Stirling County and Midtown Manhattan studies (1, 2). Crandell and Dohrenwend,

TABLE 5
Replication of the Items Predicting Psychotherapy
on 113 Men Not in Original Sample

NUMBER OF PSYCHIATRIC VISITS	PERCENTAGE OF ITEMS PRESENT*			
	0-2 (N = 30)	3-4 (N = 43)	5-6 (N = 29)	7-11 (N = 11)
0	90	77	48	9
One-ten	7	11.5	17	36
Ten or more	3	11.5	35	55

* One item in previous study—"wants role of government in relationship to the individual increased"—was not available, so possible score ranges from 0 to 11 items.

however, have suggested that such health items may merely reflect low social class (8).

The present study and other work (4) suggest another explanation. The NSA items may be better indicators of people who seek out physicians than of people who are mentally ill. For example, inability to concentrate under stress was *not* associated with most symptoms in table 2. Yet unpublished data have shown that this complaint is strongly associated with psychopathology.

Elsewhere, King noted that college students who made 11 or more visits to medical-surgical clinics also sought psychiatric help six times more often than did those who did not visit medical-surgical clinics at all (9). On the other hand, he found that social class, ethnic background, family stability, and students' intelligence did not correlate with whether or not they saw a psychiatrist. Unlike lower-class patients, the educated upper middle class may not tell their psychiatrist about their physical complaints; but they still complain about them to their family physician.

A second finding of great interest was that the decision to seek psychotherapy appeared to be strongly correlated with a relative absence of social supports. However, in this population, presence or absence of social supports appeared to be quite independent of physical and mental health. The conservative who went to church often and enjoyed games with his friends found it as hard to think under stress and as easy to complain of physical ill health as his more lonely, liberal neighbor. Thus social supports per se did not markedly diminish suffering; they only diminished recourse to psychiatrists.

These findings in a study of middle-aged men are congruent with the observations of Weiss and co-workers in college men (10, 11). These researchers noted that if psychopathology, as reflected by the Minnesota Multiphasic Personality Inventory, were held as a constant, then the presence of social supports (as reflected by athletic team and fraternity membership) decreased the likelihood that students would seek psychiatric help. Similarly, King found that both a large number of friends and frequent church attendance (but *not* the religious preference of the parents) were negatively associated with visits to a college psychiatric clinic (9).

Psychiatrists themselves are often liberal, nonchurchgoing, and unathletic. They some-

times view churchgoing, golf-playing, hippy-disparaging conservatives as highly defended individuals who avoid psychotherapy and who are basically unhappy if they only would admit it. But in this population, participation in competitive sports was statistically less associated with good physical health or right-wing views than with a good marriage. Most psychiatrists would agree that to be "lucky in love," one must be comfortable with aggression. Conversely, to want the government's role regarding the individual increased and one's middle-aged status quo dissolved by student activists may reflect personal loneliness and social helplessness as often as it does mature and altruistic social consciousness.

But such arguments lead into treacherous ground. A person's motives for approving or rebelling against the status quo are complex, indeed. All I am really saying is that ready recourse to psychotherapy may reflect social isolation from a variety of causes and that the mentally ill are less likely to come to the attention of psychiatrists if they have stable social relationships. To put it a different way, people who see psychiatrists have trouble in sustaining relationships.

The findings of this study must be regarded with caution. The sample is biased by being drawn from the intellectually ambitious upper middle class. But such bias permits refutation of the notion that only the socially disadvantaged confuse mental and physical anguish. Questionnaire data are always affected by unanticipated effects of wording. The data would be more reliable if 28 percent of the questionnaires had not gone unanswered. The ameliorative effects of psychotherapy upon the individuals who received it may well have obscured the fact that once overt (but now mitigated) psychological disability had originally led the men to psychiatrists. Finally, mental illness certainly is one reason for seeking psychotherapy.

Nevertheless, this report requires our profession to ask itself some prickly questions. Should scarce psychiatric manpower be used to help those with subjective or objective emotional impairment? Can the prevalence of psychiatric morbidity possibly be determined by merely focusing on those who receive psychiatric treatment? Is a psychiatric patient someone who needs or someone who seeks a psychiatrist? Finally, is it better to be men-

tally unstable, but a stoic with many friends, or is it better to be free of objective impairment, but a complainer with no friends to hear the complaints?

Perhaps the credo of the twentieth-century psychiatrist should be that of the nineteenth-century internist: "To cure sometimes, to relieve often, to comfort always."

REFERENCES

1. Leighton DC, Harding JS, Macklin DB, et al: The Character of Danger. New York, Basic Books, 1963
2. Srole L, Langner TS, Michael ST, et al: Mental Health in the Metropolis: The Midtown Manhattan Study, vol 1. New York, McGraw-Hill, 1962
3. Kadushin C: Why People Go to Psychiatrists. New York, Atherton Press, 1969
4. Vaillant GE, McArthur C: A 30-year follow-up of somatic symptoms under emotional stress, in Life Research in Psychopathology, vol 2. Edited by Roff M, Robins LN, Pollack M. Minneapolis, University of Minnesota Press, 1972, pp 199-210
5. Vaillant GE: Theoretical hierarchy of adaptive ego mechanisms. Arch Gen Psychiat 24:107-118, 1971
6. Derogatis LR, Covi L, Lipman RS, et al: Social class and race as mediator variables in neurotic symptomatology. Arch Gen Psychiat 25:31-40, 1971
7. Star SA: The screening of psychoneurotics in the Army, in Measurement and Prediction. Edited by Stouffer SA, Guttman L, Suchman EA, et al. Princeton, NJ, Princeton University Press, 1950, pp 486-567
8. Crandell DL, Dohrenwend BP: Some relations among psychiatric symptoms, organic illness, and social class. Amer J Psychiat 123:1527-1537, 1967
9. King SH: Characteristics of students seeking psychiatric help during college. J Amer Coll Health Ass 17:150-155, 1968
10. Segal BE, Weiss RJ, Sokol R: Emotional adjustment, social organization and psychiatric treatment rates. Amer Sociol Rev 30:548-556, 1965
11. Weiss RJ, Bergen BJ: Social supports and the reduction of psychiatric disability. Psychiatry 31:107-115, 1968

IMPORTANT NOTE: The Editor calls your attention to the statement on page 736 of this issue concerning the changes to come in *The American Journal of Psychiatry*.

1972 Anniversaries

BY GEORGE MORA, M.D.

The author recalls this year's anniversaries of events and individuals prominent in the history of medicine, psychiatry, and psychology and briefly examines their practical or theoretical contributions to the field.

1572

DANIEL SENNERT was born in Breslau. Sennert, a successful physician of the time, graduated in philosophy in 1601 and in medicine in 1602 from the University of Wittenberg. He became professor of medicine at the same university at the age of 35. He has been considered a precursor of the iatrochemists because of his corpuscular theory, which attempted a compromise between the chemical doctrines of Paracelsus and those of Aristotle and Galen. In his encyclopedic *Institutiones Medicae et de Origine Animarum in Brutis* (*On Medical Principles and on the Origin of Souls in Brutes*; first volume, 1611) and especially in his *Liber V: Practicae Medicinae* (1634), he thoroughly distinguished melancholia from mania, which he still attributed to the power of the devil. He also believed in lycanthropy and in the demoniacal transformation of human beings into animals. In spite of this, he anticipated some interesting notions on prognosis and on the alternation of melancholia and mania. His treatment consisted essentially of physical means, cathartics, and diet. Among his other works are *De Suffocatione Uteri* (*On Uterine Suffocation*, 1660), which deals with the traditional concept of the influence of the uterus on mental diseases. His *Opera Omnia* was published in 1666. After having successfully fought seven

epidemics of bubonic plague, he finally succumbed to the disease himself in 1637.

1672

Thomas Willis' *De Anima Brutorum* (*On the Soul of Brutes*) was published in Oxford. It had been preceded by his *Cerebri Anatome* in 1664 and *De Morbis Convulsivis* in 1667. Willis, who was born in 1621, held strong religious convictions throughout his life. After his graduation in medicine, he settled in London, where he acquired prominence as a clinician and head of the so-called "iatrochemical school." Early in his career he had belonged to the inner circle of the eight fellows of the "Great Club," who were very interested in experimental research (Boyle and Hooke were among the members). Elected a member of the Royal Society in 1667, he continued to combine research with clinical practice in London.

In his books on neurology, under the influence of Descartes and Gassendi, he accepted the notion that animal spirits run from the periphery to the brain and from there to the muscles. Voluntary motion was controlled by the corpus striatum; involuntary movement, by the cerebellum. He was among the first to describe the anatomy and function of the vagal and intercostal (sympathetic) nerves, thus anticipating modern autonomic notions of emotions and of psychosomatic medicine. He attempted to explain even psychiatric symptoms, such as nightmare (incubus) and hysteria, by the movement of the animal spirits. According to some, he was the first to use the term "reflex action."

Regardless of the controversies raised by some of his contemporaries concerning the accuracy and originality of his observations, his name is universally attached to the description of the arterial system at the base of the brain (circle of Willis). In the English translation by Pordage of his work *De Anima Brutorum*, the word "psychologie" was used

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for the first time in English. Willis died in 1675.

The Dutch scientist François de la Boe, or Du Bois (latinized Sylvius) died in 1672. Having graduated from the Medical School of Basel, he became a professor at the University of Leiden, where he built a famous laboratory. His lectures on anatomy, physiology, and clinical medicine drew students from all parts of Europe. A follower of the humoral theory, he explained all diseases chemically, according to the Galenic tradition. He also investigated the functions of the brain. His name is associated with the "aqueduct of Sylvius," which is a small channel connecting the third and fourth ventricles in the brain. In the realm of psychiatry, he ascribed convulsions to abnormality in the working of the bony structures of the body. He also observed that at times a physical disease makes certain mental symptoms disappear.

1772

Antoine Le Camus died in this year. Born in Paris in 1722, he graduated in medicine in 1745. In 1766 he was appointed to the chair of surgery of Clermont and in 1768 to the Royal College of Physicians of Nancy. He was involved in the organization of the institution of Salpêtrière in Paris for women rejected by society (paupers, prostitutes, criminals, etc.). His most famous work was *La Médecine de l'Esprit* (1753), in which he illustrated the causes that influence the dispositions of the mind, on the basis of a discussion of sensibility, imagination, reasoning, judgment, and memory. He felt that heredity, sex, temperament, climate, seasonal influences, education, and training also play a role in the development of mental illness.

Herder's *On the Origin of Language* was published. Gottfried von Herder (1744-1803) was born in East Prussia and studied at the University of Königsberg, where he was influenced by Kant and J.G. Hamann (the so-called "Magus of the North"). For several years, as a tutor of the Prince of Holstein-Eutin, he lived in Paris, Hamburg, and Strassbourg. In Strassbourg he became acquainted with Goethe, and through him obtained a series of official positions at the Court of Weimar, where he spent the rest of

his life. His main works include the incomplete masterpiece *Ideas for a Philosophy of the History of Mankind* (1784-91), in which he postulated a relationship between nature (man's physical environment) and the cultural evolution of the human race and described human history as evolving from God's plans.

Herder has been considered a forerunner of dynamic psychology, especially because of his emphasis on the unity of psychological functions, which all interact with each other and with the body. He conceived of man not as passive, but as active, on the basis of his ability to make choices. In contrast to other representatives of the Enlightenment, Herder saw in man a living unity of thinking, acting, and feeling, and he saw in all acts the multiplicity of the creative human spirit.

In Paris Helvetius' book *On Man, His Intellectual Faculties and His Education* appeared posthumously. Helvetius was born in Paris in 1715 and died there in 1771. In his first work, *De l'Esprit* (1758), he asserted that human actions, even the most noble ones, are caused by self-interest and egoism and that morality, legislation, and education have to be based solely on their usefulness to the community. In his later book *On Man*, he tried to convince educators and legislators that genius, virtues, and talents, rather than being caused by differences of the sense organs, resulted from the effects of education. He believed that society's aim should be "the greatest possible pleasure and the greatest possible happiness of the greatest number of citizens." His ideas had a great impact in England, where Helvetius was considered a forerunner of the Utilitarians, Jeremy Bentham and James Mill. In France, however, his works were condemned by the Catholic Church because he denied free will and a spiritual element as the basis of thought processes.

The psychiatrist Ferdinand Autenrieth was born in Germany. Before his graduation at the age of 20, he had studied yellow fever in the United States and then, in 1797, obtained a teaching position at the University of Tübingen, of which he later became president. A man well versed in many areas of natural sciences, medicine, philosophy, and theology, his importance to psychiatry lies in his close association with Johann Christian Reil (1759-1813) and in his concrete views on

the treatment of mental patients, rather than in theoretical formulations. He showed great insight in his optimistic outlook on acute psychoses and in his description of the inclination toward relapse in climacteric melancholia. On the assumption that patients should be considered children vis-à-vis the psychiatrist, he devised a special metal mask (*Autenrieth'sche Maske*) to restrain patients from shouting or making loud sounds, as well as other gadgets, such as a movable stockade, later described by Kraepelin. Among his patients was the poet Friedrich Hölderlin (1770–1843). Autenrieth also wrote on legal-psychiatric matters. He died in 1835.

1872

In the United States, several important events took place. In Elgin, Ill., the Illinois Northern Hospital for the Insane was opened under the direction of Dr. A. Kilbourne. It was originally designed for 150 patients, but by 1875 there were 525 patients; in 1878 two cottages for convalescent patients were opened. In Jacksonville, Ill., the McFarland Retreat for the Insane was opened under the direction of Dr. A. McFarland; there were 20 patients. The Essex County Hospital for the Insane was established in Newark, N.J., under the superintendency of Dr. J. Leonard, for 350 patients.

In Catonsville, Md., Dr. W.G. Steward was appointed director of the new Maryland Hospital for the Insane (Spring Grove). Its population increased from 320 patients to 400 in 1887. A chair of psychological medicine was established at the Missouri Medical College and J.K. Baudur was appointed to it. Dr. Baudur had previously opened the Clinic on Nervous Diseases and Insanity at St. Vincent Insane Asylum. John H. Callender, superintendent of the Tennessee Asylum, was appointed Lecturer Upon Insanity: Its Causes and Treatment in the Medical Department of the University of Nashville. Elected president of the Association of Medical Superintendents of American Institutions for the Insane in 1883, he delivered the first presidential address.

In Canada, the Asylum for the Insane was opened in London, Ontario, for 540 patients, under the superintendency of Dr. H. Landor.

Twenty years later the capacity of the hospital was 900 patients.

In Italy, a chair of psychiatry was established at the University of Rome. Prof. G. Girolami, director of the mental hospital of Rome, held it first. Later on, this chair was occupied by other well-known scientists, notably S. De Sanctis (1862–1935), who anticipated important concepts of child psychiatry, and U. Cerletti (1877–1963), who introduced electric shock in the late thirties.

In Germany the mental hospital of Lindenburg, near Cologne, was opened for 180 patients. Bernard von Gudden (1824–1886) was named superintendent of the mental hospital of Munich. He had previously been in charge of the mental hospital of Werneck and then of the mental hospital of Burghölzli, near Zurich. While in Munich, he became involved in the treatment of the "insane" King Ludwig II of Bavaria.

Illustration of the Influence of the Mind Upon the Body in Health and Disease, by Daniel Hack Tuke, was published in London. Born in York in 1827, he was the son of Samuel Tuke, who had followed the pioneering reform introduced at the York Retreat by his father, William Tuke, at the end of the 18th century. Daniel Tuke was elected to the Royal College of Surgeons in 1852, and the following year he received a medical degree at the University of Heidelberg. After an extensive visit to many mental hospitals on the Continent, he returned to York to take charge of the Retreat.

In 1858 he and J.C. Bucknill published the *Manual of Psychological Medicine*, which presented a new classification of mental diseases, based on the most outstanding symptoms. In 1880 he took over, with George Savage, the editorship of the *Journal of Mental Science* (now the *British Journal of Psychiatry*), which he maintained until his death. Two years later his *Chapters in the History of the Insane in the British Isles* appeared, followed by *The Insane in the United States and Canada* (1885), which resulted from an extensive trip to this country. Finally, in 1892, his important *Dictionary of Medical Psychology*, to which 67 specialists contributed, was published. He died in 1895.

Expression of the Emotions in Man and Animals by Charles Darwin (1809–1882) appeared in London. Darwin had by then already become a celebrity, mainly through his two books *The Origin of Species* (1859) and *The Descent of Man* (1871), in which he advocated the theory of evolution, based on many observations gathered during his years of study on plants, animals, and geology. In *Expression of the Emotions*, he advanced the idea of the evolution of the mind, based on the progressive differentiation of anatomical structures in animals and on the continuity of functions from animals to man. Historically, Darwin's ideas fit into the centuries-old belief of a correspondence between morphological and psychological traits, which acquired prominence during the Renaissance and anticipated phrenology. Darwin's merit was to present this theme in a scientific way, which led to the development of comparative physiology and modern psychology.

The American psychiatrist John J. Butler (1802–1890) retired from the superintendency of the Hartford Retreat, which he had held for almost 30 years. He had received a medical degree from Jefferson Medical College in Philadelphia in 1828. During ten years of practice in Worcester, Mass., he came under the influence of Dr. Samuel Woodward, then superintendent of the State Lunatic Asylum at Worcester. In 1839 he was appointed superintendent of the Boston Lunatic Asylum, where he introduced a vast program of reforms, described by Dickens in his *American Notes* in lively and favorable terms. For political reasons, Dr. Butler left this position after a few years. In 1843 he was elected superintendent of the Hartford Retreat, where he developed many innovations along the lines of "moral treatment." In 1844 he was among the 13 founders of the Association of Medical Superintendents of American Institutions for the Insane, of which he served as president from 1870 to 1873. He was also an honorary member of the Medico-Psychological Association of Great Britain and president of the first State Board of Health in Connecticut. In his book *The Curability of the Insane* (1887), Butler emphasized that a great number of the mentally ill could be cured with the help of proper medical and moral means, particularly in-

dividualized treatment; those who could not be helped should be kept in separate institutions. In an address on "State Preventive Medicine" (1879), he advanced pioneering views on the importance of the prevention of mental disorders.

The book *Mind and Body* by Alexander Bain (1818–1903) appeared. Bain was influenced early by John Stuart Mill, George Grote, and Thomas Carlyle. He was appointed professor of mathematics and moral philosophy at Andersonian University, Glasgow, and later at Bedford College for Women as well. His early works, *The Senses and the Intellect* (1855) and *The Emotions and the Will* (1859), were well received and highly esteemed, even by the American psychologist William James. Appointed professor of logic at the University of Aberdeen in 1860, he founded the important philosophical journal *Mind* in 1876 and contributed to it for many years. He later wrote a biography of John Stuart Mill, as well as an autobiography that was published posthumously. In *Mind and Body* he showed a scientific attitude toward psychological problems and recommended an investigation of the physical and physiological correlates of mental states; he produced some initial systematization of psychological theory. Today he is considered one of the founders of modern psychology.

Du Bois-Reymond delivered his famous lecture "On the Limits of the Knowledge of Nature" in Leipzig. Born in 1818 in Berlin, Emil du Bois-Reymond soon became the favored pupil of Johannes Müller, the father of modern physiology, and succeeded him in the chair of physiology in 1853. By that time he had become well known in academic circles as the leader of an ideological school that attempted to explain life in mechanistic terms. Du Bois was bitterly opposed to any form of vitalism; he strongly believed that only the common physical-chemical forces are active within the organism and that phenomena unexplainable by this principle had to be reduced to the force of attraction and repulsion. This school, which gave impetus to the so-called "biophysical movement of 1847," was also represented by Ernst Brücke, Carl Ludwig, and Hermann Helmholtz, and eventually came to be known as "the school of Helmholtz." It played a sig-

nificant role in the foundation of the theoretical postulates of psychoanalysis, since Freud was deeply influenced by Brücke.

Du Bois's main scientific contribution consisted of his research on the electric physiology of the muscle. In his famous Leipzig lecture, as well as in other writings of his late years, he dealt with methodological aspects of science by solemnly asserting "Ignorabimus," i.e., the deep essence of the functions of the mind will always remain outside of the realm of knowledge. Du Bois, for many years secretary of the Prussian Academy of Science, died in 1896. Among his pupils were Wilhelm Wundt, the founder of experimental psychology; Ivan Sechenov, the father of Russian physiology; and Vladimir Bekhterev, the Russian pioneer of reflexology.

The Birth of Tragedy, by Frederick Nietzsche (1844–1900), was published in Basel. Then an exceptionally brilliant young professor of Greco-Latin philology, he was forced to resign seven years later, due to illness. He spent the rest of his life wandering from place to place and writing books in the form of aphorisms, until he succumbed to complete insanity due to general paresis in his last 11 years. Nietzsche's work is considered the forerunner of many ideas of dynamic psychiatry. In *The Birth of Tragedy*, his only systematic work, he opposed the apollonian art (figurative art and epic poetry), stemming from dreams, to the dionysian art, stemming from drunkenness. He asserted that in dreams "some primeval relic of humanity is at work which we can scarcely reach any longer by a direct path."

In brief, his main concept centered around man's will to power, which expresses itself in the interplay between unconscious wishes and societal mores. Having postulated the unconscious as the essential part of the individual and the conscious as the cryptic manifestations of the unconscious, he gave flashes of insight into sublimation, repression, Christian morality as a form of resentment, the genesis of moral conscience from aggressive instincts, and the origin of guilt feelings as based on self-destructive instincts. Also, his concepts of "superman" and of the "eternal return" have psychological implications. Many, beginning with Freud, have found correlations between the "unmasking trend" of psychoanalysis and Nietzsche's ideas. In general, Nietzsche may

be considered as the common source of Freud, Jung, and Adler. The interaction of Nietzsche's creativity with his mental illness has also been the subject of much discussion from the psychological perspective.

Felix Voisin (born in 1794) died in this year. Voisin was early influenced by Gall, Esquirol, and Jean-Pierre Falret. With Falret, he founded the private hospital of Vanves, which soon became famous. In 1826 he published *Des causes morales et physiques des maladies mentales*, in which he dealt extensively with the relationship between genius, insanity, and crime. Eventually he became interested in the treatment of idiots at the mental hospital of Bicêtre. In his late work *Études sur la nature de l'homme considéré comme être animal, moral et intellectuel*, he thoroughly discussed animal, moral, and intellectual faculties and stressed the dependence of ethics on psychology.

The German psychiatrist August von Solbrig died in Munich. Shortly after his graduation in medicine from the University of Munich, he traveled in Germany, Belgium, and France, where he visited psychiatric institutions. Following a year of training under C.W. Ideler in Berlin, he spent several years in general practice. In 1846 he was named director of the mental hospital of Erlangen, which he had helped to organize. Three years later, in 1849, he was given a professorship of psychiatry in that same city. After considerable difficulties, he succeeded in opening a mental hospital in Munich in 1859, of which he became the superintendent. In 1864 he was called to the chair of psychiatry at the University of Munich, which he held until his death. Solbrig was especially involved in his mission to introduce the teaching of psychiatry into the medical curriculum.

Michael Von Viszanik, born in 1792 in Szatmar, Hungary, died in Vienna in this year. He had studied in Pest and Vienna, where he graduated in medicine in 1822. There he was among the few who became interested in the treatment of the mentally ill, so he was appointed physician of the local mental hospital, which consisted mainly of the so-called "Irrenturm," a tower-like building for the insane erected by order of the Emperor Franz Joseph II. Viszanik introduced many

innovations, such as "observation rooms" and hydrotherapy, partly as a result of some visits to institutions in England, France, and Switzerland. On the basis of his broad experience in the field of mental illness, he made plans for the construction of a new mental hospital in Brünnefeld. In 1844 he was called to the position of "public academic teacher of theoretical and practical psychiatry" in Vienna. He also founded the Association for Persons in Need of Assistance Discharged from Austrian State Institutions in 1851.

Karl Spurzheim, a nephew of the phrenologist Johann Spurzheim, died in Vienna, where he had been born in 1809. After graduating in medicine in 1835, he undertook a long trip to visit mental institutions in Germany, France, and Belgium. He was named senior psychiatrist at the mental hospital of Ybbs in 1842, and introduced many enlightened reforms there in the treatment of the inmates. He became superintendent of that institution in 1859. Ten years later he succeeded J.G. Von Riedel (to whose reforming spirit he had been very close) as director of the Mental Hospital of Vienna. Spurzheim dedicated much energy to the improvement of legal reports on mental patients, according to the German psychiatric tradition. In 1871, he was elected president of the Association of Psychiatry and Neurology.

Krafft-Ebing was named professor of psychiatry at the University of Strassbourg, newly reorganized by Bismarck after Germany's victory over France in the previous year. Richard Freiherr von Krafft-Ebing was born in Mannheim in 1840 and studied in Heidelberg under Virchow, in Zurich under Griesinger, and then in Vienna, where he was influenced by Skoda, Rokitansky, and others. Eventually he returned to Germany and, after four years as assistant physician at the Men-

tal Hospital of Illenau, he decided to settle down in private neurological practice in Eaden-Baden. However, he was soon called by the Army during the Franco-German war and while serving did research on the neurological aspects of typhus. In 1874 he left Strassbourg and moved to Graz, Austria, where he opened a psychiatric clinic, which he directed for four years. In 1886 he became professor of psychiatry at the medical school at Graz and, under his influence, the fields of neurology and psychiatry were united. There he founded the sanatorium of Mariagrün, which soon acquired world renown. In 1889 he was called to head the psychiatric clinic of the University of Vienna, where he worked closely with Theodor Meinert, whom he replaced at Meinert's death in 1892.

As part of his aim of combining psychiatry and neurology, he founded the Society for Psychiatry and Neurology in 1894, followed shortly by the publication of the prestigious *Jahrbücher für Psychiatrie und Neurologie*. By that time, Krafft-Ebing had become well known for his many contributions to psychiatry. Among them are: the description of obsessional ideation and confusional states; the publication of his *Textbook of Psychiatry* (1869), based on an enormous amount of clinical experience; his studies on the etiology of general paresis and of "tabes dorsalis"; his collected *Works from the General Fields of Psychiatry and Neurology*; his important *Textbook of Legal Psychopathology*; his *Psychopathia Sexualis*, translated into many languages and republished up to our day, in which he anticipated many concepts of dynamic psychiatry; his research on the therapeutic influence of hypnosis; his monograph on the *Psychosis Menstrualis* (1902); and his efforts to improve conditions for nervous and mental patients in psychiatric institutions. Krafft-Ebing died in 1902, shortly after his retirement from the chair of psychiatry at Vienna.

The Pseudo-Regulation of American Psychiatry

BY ROBERT L. TAYLOR, M.D., AND E. FULLER TORREY, M.D.

The self-regulation of American psychiatry has evolved into a form of professional protectionism that fails to ensure appropriate and competent psychiatric service providers. Despite an elaborate regulatory facade, the fact remains that to practice as a psychiatrist in this country requires nothing other than a medical license. The authors suggest changes in the existing regulatory process including outside representation, mandatory psychiatric certification and periodic recertification, and proficiency standards.

AMERICAN PSYCHIATRY vividly illustrates the inadequacies of the self-regulation of professionals. Whereas effective regulation should ensure competent service providers, self-regulation tends to evolve into protectionism that focuses on guaranteeing professional advantage and freedom from outside encroachment.

The self-regulation of American psychiatry occurs through a complex organizational arrangement involving the American Medical Association and the American Psychiatric Association. The resulting regulatory structures have a built-in tendency to advance professional interest over public interest when the two come into conflict. We are not implying that there is an active psychiatric conspiracy at work to take advantage of the public. Rather, we are suggesting that the process of self-regulation operates with a structural bias that has a way of changing regulation into protectionism.

Certification of individual psychiatrists and accreditation of psychiatric training pro-

grams are the two components of existing psychiatric regulation. The "regulating" body for psychiatric certification is the American Board of Psychiatry and Neurology. Four of the members are appointed by the American Psychiatric Association, four by the American Neurological Association, and four by the American Medical Association (usually two psychiatrists and two neurologists). The result is six psychiatrists and six neurologists who, in most cases, tend to their own half of the shop.

Although the Board has been described as an independent agency, in fact it was established under the sponsorship of the AMA. Even the nature of its membership was determined from the beginning by the AMA (1). Structurally, the Board is not independent from the interests of its parent organizations—the APA and the AMA. It represents a kind of organizational incest. Currently the six psychiatrists on the Board include one past president of the APA, two past chairmen of major APA committees, and one past and one present APA trustee. There is no nonprofessional, public representation. This exclusive medical-psychiatric composition of the Board is evident in the position it has taken on psychiatric certification.

The Certification of Psychiatrists

The American Board of Psychiatry and Neurology has consistently advocated a policy of voluntary certification. This is reflected in the fact that approximately two-thirds of the nation's psychiatrists practice without certification, making psychiatric certification somewhat like Swiss cheese—more holes than substance (2).

In the absence of specialty licensure requirements, the Board's failure to establish a mandatory standard of competence means that to practice psychiatry requires nothing more than a medical license. *No training or proficiency in psychiatry is required.* If the

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1-5, 1972.

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Board cannot bring itself to establish a policy of mandatory certification, at least it could actively advocate a specialty licensure requirement for psychiatry. The fact that it has done neither seems unreasonable. Either psychiatrists need certain skills to practice competently, in which case the Board should require that they demonstrate these requisites before offering their services to the public, or psychiatrists need no such skills apart from having trained as medical doctors, in which case the Board should consider disbanding. Unfortunately, neither course of action seems imminent.

In view of the Board's position on certification, it is not surprising that it has failed to advocate periodic recertification. Theoretically, a man could pass the Board examination at age 31, enter the field of engineering for the next 30 years, and return to psychiatry at age 61 as a full-fledged, Board-certified psychiatrist. The absence of mandatory periodic reexamination, with its inherent incentive for continuing education, is a serious shortcoming in psychiatry. Although recertification would undoubtedly create some professional inconvenience, there can be little question that it would serve the public interest as a measure of quality control.

Paradoxically, even though the Board is an essential part of the porous regulatory process that allows uncertified psychiatrists and physicians without specialty training to practice psychiatry, it retains strict eligibility requirements for entrance to its own examinations. These requisites limit Board eligibility to medical school graduates who have had three years of specialty training in an accredited psychiatric training program and two years of documented postresidency experience (3).

By placing emphasis on the number of years of training and the types of settings in which the training must occur, members of the Board have avoided the more difficult and fundamental question of what an individual must develop in the way of attitudes, skills, and knowledge in order to practice competently as a psychiatrist.

The two-part certifying examination given by the Board is an inadequate answer to this question. It is a voluntary examination; moreover, performance on it has never been correlated with psychiatric effectiveness. In this sense it is essentially meaningless as a basis

for certification. The Board has never established that its examination measures the ingredients necessary for psychiatric practice. Because of its failure to establish performance criteria that correlate with psychiatric competence, the Board has been forced to rely on an arbitrary time-and-curricula requirement for psychiatric training that has created serious educational deficiencies.

First, the structure of psychiatric training as prescribed by the Board completely disregards individual interests and learning differences. Instead of specifying certain minimal performance standards for the practice of general psychiatry as well as the various psychiatric subspecialties, Board members specify the same core training program at the same rate of speed for all residents. Consequently, with the exception of some elective time, future community psychiatrists, behavioral researchers, psychotherapists, mental health administrators, and psychiatric educators all have similar training. Furthermore, with complete disregard for the fact that residents enter psychiatric residencies with differing levels of knowledge and varying learning efficiency, Board members require all residents to spend the same period of time learning this core curriculum. Such a policy indicates little understanding of the effect of individual motivation on the learning process. George Miller (4), Director of the Center for Research in Medical Education, has commented on this lack of understanding among Board members generally:

In a moment of quiet reflection, these leaders might be willing to acknowledge the fundamental biologic truth of individual differences, but they give little evidence of readiness to act upon the educational corollary that individual residents with varied backgrounds, skills, interests, and motivation will learn at different rates, by different means, and might move toward the objectives of a specialty training program by many paths and at different speeds. If there were *genuine* acceptance of this principle, then boards would concern themselves largely, if not exclusively, with the task of determining whether candidates had acquired requisite competence, not with the time it took nor the means by which it was accomplished (4, p. 601).

A second educational deficiency that stems from the Board's strict time-place training requirements is the general overtraining of psychiatrists. By supporting the necessity for a complete medical education plus an addi-

tional five years of training and experience, Board members have played their part in guaranteeing that psychiatrists are trained for a fantasy profession.

Looking over the educational background of a psychiatrist, a Martian newly arrived on this planet might reasonably predict that this professional's practice would consist of performing tonsillectomies, delivering babies, and treating heart failure and epilepsy, while engaging in psychotherapy on the side and organizing the community in the evenings. It is questionable that such gross overtraining is in the interest of producing more effective psychiatrists; more likely, it serves to protect against territorial encroachment by "lesser trained" professionals. As stated by one professional: "The amount of esoteric knowledge in the profession which is claimed as the basis for authority is grossly exaggerated" (5).

In its effort to protect the medical identity of psychiatry, the Board has established some requirements that border on the absurd. For example, an individual who has had two consecutive years of training in any medical or surgical specialty may substitute this experience for a year of psychiatric experience (3). This means that a person with two years of training in colon and rectal surgery may count this as a year of experience in psychiatry. In contrast, a person who has had two years of experience as a Ph.D. clinical psychologist cannot receive credit because psychology is not a medical specialty. This is an example of protecting the medical borders of the profession against encroachment rather than ensuring the public of capable psychiatric practitioners.

The Accreditation of Psychiatric Training Programs

The second component of psychiatric self-regulation focuses on the accreditation of training programs. This is the function of the Joint Residency Review Committee for Psychiatry and Neurology. Six psychiatrists serve on this committee; no interest other than that of the APA and AMA is represented.

The committee meets twice a year to review applications for training program accreditation. The deliberations of the review committee are held in private; thus, the actual

basis for accrediting decisions remains largely unknown to training programs. Routinely, as many as 100 separate programs are acted upon in a single session, making in-depth training program review impossible (6). Review committee members assess training programs on the basis of written applications and supplementary comments of the field staff. At present the field staff of the Residency Review Committee of Psychiatry and Neurology consists of ten semiretired physicians with an average age of 66. Of these ten physicians, only one is a psychiatrist (7). Directors of psychiatric training programs are familiar with the experience of trying to explain their programs to a retired ophthalmologist or urologist. With this kind of field staff, the validity of the entire accrediting process seems questionable at best.

Usually at least two programs are assessed each workday by a single member of the field staff; sometimes the number rises to four or five. One staff member summed up his approach to evaluating a psychiatric training program this way: "My role is to just get a personal impression. I need to talk with the administrator and get a general picture, and I always like to survey the facilities and look over the grounds." Out of approximately 150 programs evaluated, this same person had written unfavorable reports on fewer than five percent.

Another field staff member, when asked if he had difficulty reviewing psychiatry programs since his own training was in another specialty, commented that it was simply a matter of gradually developing a checklist. If the committee disapproves a program that he has reviewed, he assumes that his major findings were viewed negatively by the committee. In this fashion he "collects a list" of program weaknesses. One has to be impressed, however, by how slowly his list has grown. In three years of field staff work this particular reviewer had not recommended disapproval of a single program.

This uncritical approach to psychiatric training program review is standard operating procedure. In 1967-1968, for instance, only two out of 242 existing programs had their accreditation withdrawn (3). Since more than 40 of these programs had attracted only a single resident, this approval-withdrawal ratio is truly remarkable.

The residency review application form—

completion of which is required of all programs applying for accreditation—reads like psychiatry in the late 1800s. True to the medical tradition, the form has a section for listing the number of consultants available in tuberculosis, anesthesia, and urology. The overall emphasis is quantitative; questions focus on how many staff, how many hours of supervision, how many patients, how many volumes in the library. In contrast, fundamental inquiries concerning quality of training are notably absent. There are no specific questions concerning community mental health training. No information is required about what trainees do when they finish their training. There is no concern for the efficiency of training—the cost per trainee.

The most damaging aspect of this current system of training program accreditation is its destructive influence on the evolution of psychiatric education. Training programs, in order to ensure continued approval, must conform to rigid requirements. Experimentation in developing psychiatric manpower that is more relevant to the public need must be curtailed in order to maintain an accreditation upon which federal support is dependent.

Summary and Recommendations

The self-regulation of American psychiatry is a facade that hides the absence of meaningful regulation from the public eye. Despite the regulatory activities of the American Board of Psychiatry and Neurology, the Joint Residency Review Committee, and the various state governments, the fact remains: *to practice psychiatry in this country requires nothing other than a medical license. No demonstrated psychiatric competency is required.* A public-oriented system of professional regulation, in contrast, would ensure that only qualified service providers are allowed to practice. At the same time it would attempt to eliminate excessive requirements that have no relationship to competent practice but that create an unnecessary manpower shortage with its inherent expense and inconvenience to the consumer.

Changes in the existing self-regulatory system are essential if meaningful regulation of psychiatry is to be achieved. We suggest three such changes.

1. Outside Representation

Other human service professionals and lay advocates should be added as members of the American Board of Psychiatry and Neurology and the Joint Residency Review Committee. This would create a broader perspective and a healthy antagonism that could provide a basis for the fair mediation of differences between public need and psychiatric professional interests.

2. Mandatory Psychiatric Certification and Periodic Recertification

Until this becomes part of the regulation of psychiatric practice, the certification process will continue to be a rite-of-passage, a "status trip" for interested psychiatrists, rather than a means of ensuring psychiatric competency. Psychiatrists who are considering taking the existing certifying examination should seriously question giving their support to this inadequate regulatory procedure, the major achievement of which is to hide the fact that there essentially is no regulation of psychiatry.

3. Proficiency Standards

The establishment of proficiency standards for psychiatric practice will necessitate a drastic shift from the present emphasis on amount and kind of training to a focus on performance criteria. This would require the development of assessment procedures that can measure the necessary knowledge, skills, and attitudes required for psychiatric practice. Once established, however, proficiency standards should not remain static. They should undergo continuing modification as new service problems arise and more effective approaches are identified.

American psychiatry represents an important study of whether a professional discipline can learn to adequately regulate itself as well as protect itself. The outcome of the profession's efforts will to a large extent determine the roles that state and federal agencies may have to play in future regulation.

REFERENCES

1. Freeman W: *The Psychiatrist: Personalities and Patterns*. New York, Grune & Stratton, 1968
2. *The Nation's Psychiatrists*. Public Health Service Publication 1885. Rockville, Md, National Institute of Mental Health, 1969

3. Directory of Approved Internships and Residencies 1969-1970. Annual Report on Graduate Medical Education in the United States. Chicago, American Medical Association, 1969
4. Miller GE: The Orthopaedic Training Study. JAMA 206:601-606, 1968
5. Reiff R: The Anti-Profession. New York, Center for the Study of Social Intervention, Albert Einstein College of Medicine, 1970 (processed)
6. Mixtère G Jr (Assistant Director, Department of Graduate Medical Education, AMA Council of Medical Education, and Executive Secretary of Residency Review Committee for Psychiatry and Neurology): Personal communication, Apr 22, 1971
7. Ruhe CHW (Director of Medical Education, AMA): Personal communication listing AMA Division of Medical Education Field Staff, May 4, 1971

DISCUSSION

HARVEY J. TOMPKINS, M.D. (New York, N.Y.)—In this provocative paper, the authors graphically indicate the deficiencies in what they describe as "the self-regulation of psychiatry by professionals." While they disclaim the presence of a conspiracy, it is alleged that this permits them to charge the "regulators" with a bias at the expense of the public interest. I find no support of this allegation in my own experience or in this paper. The authors conclude with the caution that if the professionals don't do better, federal regulation will be required. One may be allowed to question whether such intervention will result in a bettering or worsening of the present situation.

The authors draw attention to the large number of physicians legally practicing psychiatry who are not Board-certified. The suggestion is made that the Board provide for mandatory certification or work toward specialty licensure. The ABPN, like other medical specialty boards, was instituted as a voluntary, nonprofit, nongovernmental organization sponsored by similarly organized professional organizations as one method of bettering patient care through improvement of medical education. Training programs are accredited on request and their graduates are examined by the Board if they so desire. The Board is an autonomous, legally incorporated medical body with the responsibility of developing its own constitution and by-laws, as well as its own policies and procedures, and whose services are available on a voluntary basis. It is composed of representatives from three sponsoring bodies, but the individual directors are responsible only to themselves and to the Board.

Because of the increasing professional influence of the various medical boards—and not because of any inherent right or authority—clinic, hospital, and faculty appointments, raises in staff levels, and funding from various sources have been increasingly dependent on Board certification. This has placed the boards in a quasi-public status, a posi-

tion neither sought, encouraged, or supported by the boards. The requirement of mandatory certification before practice of a specialty through licensure or other legal means is a question that can best be answered by the medical fraternity, academic institutions, and representatives of the public. If it is affirmed, one can assume that appropriate legal instruments would be instituted to implement such legislation.

I am ideologically against such actions, and I believe that if these laws and procedures are enacted, it can logically be assumed that similar actions will be considered in regard to where the physician practices (based on the complaint of maldistribution of physicians) and how he practices (to conform with particular methods of delivery of his services). All this brings to mind the state medical programs that exist in Eastern Europe.

While the basic criteria are elaborated in the *Directory of Approved Internships and Residencies* of the AMA, the 1972 *Guide for Residency Programs in Psychiatry and Neurology* states in its foreword that the Residency Review Committee "recognizes that sound graduate education may be acquired in different ways and that training methods must change with the advance of medical science and the resulting increase in knowledge. This Guide is, therefore, to be regarded as expressing current attitudes of the approving agency and not as fixed, static requirements."

When eligibility for the examination is determined, I am personally aware that the same flexibility exists, with the avoidance of the kinds of extremes suggested by the authors.

The problem of recertification is receiving attention by this and other boards; no board seriously doubts the need to formalize the requirement of the continuing education of the physician. What form this will take is debatable. The Board of Family Practice provides for recertification, and others will follow.

The most telling comments of the authors are contained in their criticisms of present examining procedures. While exceptions are made by this and other boards, I believe the retention of a specific period of time for training is principally due to the acknowledged inadequacies of our examination methods. Belatedly, both the ABPN and other boards are accepting their responsibility to provide for a continuing examination of testing procedures leading to more objective evaluations of the actual performance of the physician.

In answer to the authors' criticism of the residency review mechanisms, I can only reply by indicating the AMA's desire to secure surveyors with the best possible understanding of the educational process, whatever their age or background, and also the diligence of the members of the committee in providing an equitable evaluation of the individual programs. Where doubt exists, site visits are

carried out by recognized and reputable specialists. This committee's procedures are open to public scrutiny, with due respect for the confidentiality of the details of the individual training program's inspection and evaluation.

Finally, the need for nonmedical input, whether from the public or from other professionals, is a subject of lively debate within all specialty boards,

as it is in other health areas. The AMA's Millis Report and the Carnegie Report have not only accelerated the concept of the assumption of responsibility for graduate medical education by the university but also appear to be leading toward an overall Commission on Medical Education, with representation from the general public and government.

Questions of the Month

Each of the incomplete statements below is followed by five suggested completions. Select the one that is BEST in each case.

Question 1

For an applicant to be eligible to receive federal funds for construction or staffing support under the Community Mental Health Center legislation, it is necessary that the application be formally approved by the designated mental health authority of

- (A) the state only.
- (B) the local community only.
- (C) both the state and the local community.
- (D) the National Institutes of Health.
- (E) none of the above.

Question 2

The self-regulatory tendencies of organisms refer to

- (A) dynamic internal environment.
- (B) entropy.
- (C) endogenous behavior pattern.
- (D) homeostasis.
- (E) none of the above.

(The Questions of the Month are from the Self-Assessment Program of the APA. The answers are supplied on page 668 of this issue.)

A Commentary on "The Pseudo-Regulation of American Psychiatry"

BY SHERVERT H. FRAZIER, M.D.

The efforts leading up to the formation of the American Board of Psychiatry and Neurology in 1934 reflected the two professions' attempts to protect the public interest and to separate persons who were adequately trained in the two specialties from those who were self-declared specialists. While problems have developed in recent years, efforts toward improvement are under way through experimentation with recertification, a better and more relevant type of Board examination, and other means of evaluating the competence of psychiatrists and other physicians.

IN AN ARTICLE in *The American Journal of Psychiatry* in 1959 (1) on the founding of the American Board of Psychiatry and Neurology, Inc., Drs. Walter Freeman, Franklin G. Ebaugh, and David A. Boyd, Jr., noted that the trend of "modern" medicine has been to organize, standardize, and stabilize the practice of the healing arts. This began in some form not with the Board itself but as soon as medicine had been established on this continent.

When the early asylums were established in Philadelphia, New York, and Boston, the medical superintendents of these organizations instituted a method of keeping record of case histories and other records, as well as of treatments administered to patients, who were then called "residents" of these asylums. Drs. Pliny Earle, Rufus Wyman, and Thomas Lee attempted to create standards of ethical practice and professional competence based on knowledge of adequate fundamentals of medicine pertaining to mental health.

The certification of medical schools after

the Flexner report, the classification of the Class A types, the slow disappearance of the less competent schools, and the painful disappearance of the strange healing cults led to a general awakening within the profession to the need for continuing studies of areas of knowledge and clinical competence that would make the practitioners safe for the public. In psychiatry many self-constituted specialists declared themselves competent promulgators of wisdom relating to emotional illness, and often these were abetted by local politicians and the abdication of responsibility by other physicians—to the latter's detriment.

All medical specialties were confronted with the same problem. In the early decades of this century the societies of the various specialties attempted to solve the problem by establishing boards of certification. Adolf Meyer, in his presidential address to the American Psychiatric Association in 1928 (2), recommended that as a part of the program of our Association, the various centers should work out intensive courses of work looking forward to two kinds of diplomas, one for adequate basic training, the other for advanced proficiency and special creative work of note. In the March 1931 issue of *The American Journal of Psychiatry* (3), there appeared an editorial advocating the formation of an American Board of Examiners in Psychiatry. This clearly demonstrates that the impetus for certification of specialists in psychiatry arose within the psychiatric profession and not within the American Medical Association.

Through the Section on Nervous and Mental Diseases of the American Medical Association, the need for such recognition and certification was acknowledged as a cooperative function with the National Board of Medical Examiners. In 1932, the House of Delegates of the Medical Society of New Jersey em-

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barked on a program of specialty certification on a state level. They offered certification as a specialist on the basis of recommendations, memberships in various societies, appointments held, etc., but without any formal examination.

Early Attempts at Regulation

In the proposed revision of the Constitution of the American Psychiatric Association published in September 1932 (4) it was specified that an examining board of five Fellows or Life Members should be appointed by the President and approved by the Council (now Board of Trustees), and that it should be the duty of this board to make a report and recommendation to the Council on each application for each class of membership. It required the board, from time to time afterwards, to submit to the Council plans for the procedures by which it proposed to pass upon the fitness of new applicants for membership and also on present members of the Association.

The year 1933 was characterized by mounting interest in certification. The Council on Medical Education and Hospitals of the AMA resolved to extend to other special fields of medicine the services it had rendered to the fields of radiology and pathology to the end that members of the medical profession and others might be able to readily distinguish those who had received training in the various branches of medicine from those who were merely self-constituted specialists.

The first specialty board was the American Board of Ophthalmology, founded in 1916. At the Boston meeting of APA in 1933, the National Committee for Mental Hygiene and APA's officers began to set standards for "alienists." Dr. James V. May, in his presidential address (5), stressed the protection of the public as the reason for the setting of standards for alienists. The Council of APA appointed the following Fellows of the Association as the Board of Examiners: Dr. Clarence O. Cheney, chairman; Dr. Adolf Meyer; Dr. William A. White; Dr. C. Macfie Campbell; and Dr. Franklin G. Ebaugh.

The original examining board, as planned by APA, was designed to examine and certify only psychiatrists. Delegates were subsequently sent to confer with the Section on Nervous and Mental Diseases of the AMA,

meeting in June 1933. They found that the AMA section had formulated some plans for the certification of neuropsychiatrists. A committee of the section was appointed, consisting of Drs. Walter Freeman, Lloyd Ziegler, Edwin G. Zabriskie, J. Allen Jackson, and George W. Hall. Gradually the two committees came to recognize the common and logical sponsors for neurology and psychiatry. Representatives of the AMA, APA, and the American Neurological Association collaborated, with equal representation from psychiatry and neurology with four members from APA, four from the American Neurological Association, and two psychiatrists and two neurologists from the Section on Nervous and Mental Diseases of the AMA. They sounded the death knell to "neuropsychiatrists" and set up separate qualifications for neurologists and psychiatrists, with separate examinations for these two specialty groups.

On October 20, 1934, the appointees of the three sponsoring associations met at the Hotel Commodore in New York City, with Dr. Adolf Meyer acting as chairman. The attorney for incorporation was present and the Board was on its way. Dr. H. Douglas Singer was the first president, Dr. C. Macfie Campbell vice-president, and Dr. Walter Freeman secretary-treasurer. Throughout this period of development, emphasis was put on protecting the public and on the need for separating those persons who had had formal training in psychiatry and in neurology from those who were self-declared specialists. The thankless job that these founders had in the consolidation, the initial separation of the qualified from the unqualified specialists, and the persistent urging of ever-higher standards was not productive of personal popularity for the founders. The rewards of these men were long hours of grueling work and sometimes personal vilification. But they had a conviction that they were building constructively for the future of their specialties.

Recognition of the Public Interest

In the recounting of the history of the American Board of Psychiatry and Neurology we see that the philosophy of the Board, through the nearly 40 years since its founding, has continued to recognize the public interest as a prime fact. Today the Board has some problems, as has been pointed out by Drs.

Taylor and Torrey. The first problem is trying to define the goals of training for individual psychiatrists and—based on these goals—the content of the examinations. The rapid development of numerous subspecialties within the field has separated that body of information which the subspecialties now require from the core of knowledge that the general specialist in psychiatry needs. The wisdom to declare how psychiatrists will be functioning in the 1980s and 1990s has not declared itself with any unanimity.

As can be seen, the role of the examination historically has been as a strictly voluntary proposition, although the examination originally was included among the prerequisites for membership in the American Psychiatric Association. As far as making Board examinations and the certification of specialists a mandatory regulation for all psychiatrists, it seems abundantly clear to those in the area of civil liberties that the individual rights of citizens and physicians, as well as the right of the individual states to grant licensure for practice, would stand in the way. This does not limit the rights of medical specialists to advocate to the various state legislatures the licensing of specialists.

In regard to the statement that the most highly qualified psychiatrists are dealing with the least sick, APA's manpower studies refute this thesis adequately. Ambulatory schizophrenic patients are not less sick than state hospital patients. Anyone who has been in private practice or community or state-financed clinics in an urban area (where most persons now reside) is aware of the large number of borderline patients and extremely sick neurotics as well as ambulatory psychotic patients who are undergoing outpatient psychiatric treatment. The Medical Director's office of APA recently surveyed a wide range of training programs—several universities in the South, a state hospital in Oklahoma, a major mental health center in a northern New England urban area, the unique Menninger School of Psychiatry, the state-supported New York State Psychiatric Institute, and the University of Colorado—all of which train large numbers of residents.

It was a pleasant surprise to find that the percentage of graduates in solo private practice was extremely low. Curiously enough, in this survey, it was the state hospital that turned up the largest number of graduates in

solo private practice. Because this was a non-random sample the survey has limited value, but it is the only one in existence that shows where recent graduates whose training has been federally financed are practicing. A large percentage of residents who completed their training in the past five years spend part of their time in public service; a much smaller percentage are in solo private practice. It is clear that the graduates from the largest residency training programs turning out the most graduates during the past five years are dealing with the sickest part of the psychiatric patient group in the public sector.

Recertification

Recertification has begun; it is now the rule in one certifying board and relicensure is now required by law in two states. Some medical societies have rules that are requiring post-graduate education. Most of the self-evaluation examination projects of the various specialty societies are forerunners of an eventual program of recertification similar to the one adopted by the American Board of Family Practice. What form this recertification will take has not yet been divined, but the American Board of Family Practice has a research project under way to define what part will be an examination of the physician's medical records, what part will consist of a site visit to the physician's office to observe his practices, what part will be a supervised clinical examination of patients, and what part will be an examination of knowledge of recent developments in the specialty field. Certainly, with the development of the console-type, computer-based, problem-solving, patient management kind of question, which has been under study by the American Board of Internal Medicine and the American Board of Pediatrics, we will soon have available to the various boards the technology as well as the expertise to evaluate services.

Several of the medical specialty boards are trying to devise mechanisms for coordinating evaluation research related to physician competence and performance. It is necessary: 1) to define the areas in which research and evaluation techniques might lead to more valid and reliable measurements of both episodic and day-to-day physician performance; 2) to share information concerning present and future research activities of individual organiza-

tions; 3) to define those research areas in which cooperative efforts might be especially productive; and 4) to propose a mechanism through which such cooperative efforts might be carried out. The exchange of information on current research projects of specialty boards, as well as those being developed by groups outside the boards, needs to be formalized. Deficiencies in the present evaluation instruments now being used to make decisions about the physician's competence and performance underscore the need for developing a new organizational relationship among various boards to facilitate the search for new methods to evaluate physician competence. Some of the specific objectives require an understanding of the test item banks now in existence in computers, as well as the development of pretesting populations at different levels of the educational continuum, the development of cognitive psychometric and attitudinal criteria as well as the creation of non-cognitive measurement instruments, and the development of computer simulation models and human simulation models.

It is clear that many members of the medical profession are becoming increasingly aware of the need to develop better methods of evaluating whether or not psychiatrists and other physicians are competent and whether or not physicians perform adequately in the delivery of health care services. Specialty boards have begun inviting members of other specialties as well as consumers to board examinations. The American Board of Psychiatry and Neurology has had neurologists observing psychiatric examinations and is now inviting pediatricians and family practitioners as well as other specialists to observe the examinations. It is hoped that in the not too distant future representatives of consumer groups will also be invited to participate in observing the examination procedures.

Overtraining of Psychiatrists?

Whether or not psychiatrists are being overtrained is a value judgment. It is essentially clear that many other professionals and paraprofessionals are competent to assist psychiatrists and other physicians in delivering some psychiatric services. Whether or not such individuals will ever diminish the need for a larger cadre of professionally trained, medically graduated psychiatrists in the im-

mediate future is beyond my wisdom, but it is clear that within the present three-year period it is impossible for many persons to obtain the depth and breadth of training they desire. Presumably for this and for personal reasons, many graduating residents continue some form of training beyond the three years.

The Residency Review Committee, a joint group of the American Board of Psychiatry and Neurology and the AMA's Division of Graduate Medical Education, needs improvement. At the next meeting of the Residency Review Committee a proposal will be discussed concerning the institution of site visitor teams of psychiatrists to examine training programs. It is clear that the evaluation of training programs needs to be revised. Evaluation by a team of qualified specialists is essential, as is careful interviewing of the teachers and the trainees as well as careful scrutiny of the curricula and dossiers of each trainee.

It has been stated that the present Board does not allow for experimentation. Numerous programs of experimentation with the psychiatric internship, the shortening of residency training, and the combination of certain aspects of residency training in medical schools are occurring in a number of medical schools and residency training programs in psychiatry. The American Board of Psychiatry and Neurology has a long-range planning committee. This group, headed by Dr. Milton Greenblatt and composed of psychiatrists and neurologists, is proposing and is investigating the continuing change in educational patterns as well as evaluating physician performance to include the trainees from experimental programs. Pictorial material has already been introduced into the examination, patient management problems are being introduced, and the examination committee of the Board is now considering the use of standardized videotapes.

The selection of psychiatrists to serve on the American Board of Psychiatry and Neurology is essentially a function of APA and the Section on Psychiatry of the AMA. The AMA section receives nominations from APA before electing its nominees. In the past, various segments of the psychiatric community as well as different geographic regions have been represented on the Board. A commissioner of mental health (formerly a state hospital superintendent), an educator now coordinating psychiatric programs for the

Western Interstate Commission on Higher Education, a leader in general hospital psychiatry, a private mental hospital psychiatrist, and, until recently, a state psychiatric research and clinical administrator and a black academic psychiatric educator have been serving. Private practice has not been adequately represented insofar as the solo practitioner is concerned; perhaps the large time commitment required of one who serves on the Board is one reason for this.

Efforts have been made repeatedly to enlarge the Board's membership, but these have not been successful. However, training program directors, psychiatric educators and teachers, and representatives of other professional disciplines have provided questions and consultations to the Board. The Board contracts with the National Board of Medical Examiners for assistance in the construction of examinations. The examination is divided into 11 or 12 currently pertinent areas of knowledge considered essential to general psy-

chiatrists. Training program directors have been advised in the "Guidelines for Psychiatric Residency Training" of the areas in which training is presently required. The guidelines are revised every two or three years, and attempts are made to keep the training curricula as well as the examination current with the needs of the various professionals in the several echelons of the psychiatric care delivery systems.

REFERENCES

1. Freeman W, Ebaugh FG, Boyd DA Jr: The founding of the American Board of Psychiatry and Neurology, Inc. *Amer J Psychiat* 115:769-778, 1959
2. Meyer A: Thirty-five years of psychiatry in the United States and our present outlook. *Amer J Psychiat* 84:1-31, 1928
3. Ebaugh FG: Notes and Comment: The suggested American Board of Examiners in Psychiatry. *Amer J Psychiat* 87:873-876, 1931
4. Revision of the Constitution. *Amer J Psychiat* 89:389-403, 1932
5. May JV: The establishment of psychiatric standards by the Association. *Amer J Psychiat* 90:1-15, 1933

Answers to Questions of the Month

Page 663. 1:A; 2:D.

Group Drinking During Stress: Effects on Drinking Behavior, Affect, and Psychopathology

BY LAWRENCE R. ALLMAN, PH.D., H. AUGUSTUS TAYLOR, PH.D.,
AND PETER E. NATHAN, PH.D.

Three chronic alcoholics took part in a 32-day study in which relationships between experimentally imposed stress and alcohol consumption, mood, and psychopathology were explored. Subjects drank most when stress and socialization periods coincided; they drank least when stress and periods of isolation occurred together. Stress produced significant increases in tension, depression, and anger, while alcohol independently increased prevailing levels of depression and anxiety. The relevance of these findings to questions of etiology and treatment is discussed.

THE ALCOHOLISM literature contains a variety of reports relating drinking behavior to psychosocial influences. Many chronic alcoholics themselves trace their alcoholism to the "social pressure" that they see coming from wife, parent, boss, or friend. Up to this time, however, most research on the influence of psychosocial factors on the etiology of alcoholism and continued drinking by alcoholics has been relatively uncontrolled and largely anecdotal. This has come about partly because, until recently, alcohol researchers have not chosen to employ alcohol as an experimental drug in the laboratory, despite the fact that its use in this context permits controlled investigation of the behavioral concomitants of prolonged drinking, a

research capability impossible under the traditional naturalistic paradigm.

Within the last few years, two groups of researchers have studied the acute and chronic drinking behavior of alcoholics within the controlled laboratory setting. Although this has not always been their primary aim, Mendelson, Mello, and co-workers (1-4) and Nathan and his co-workers (5-7) have reported on interesting relationships between psychosocial factors and parameters of drinking behavior. Both groups have demonstrated, for example, that certain concomitants of chronic drinking—including the increase in prevailing levels of depression and anxiety that often occurs shortly after drinking has begun and the "cyclical" pattern of alcohol ingestion that commonly accompanies prolonged drinking by alcoholics—appear to be relatively impervious to psychosocial influence (1, 5). They have also identified other behaviors that accompany prolonged drinking, which do appear to be sensitive to the interpersonal climate of the group drinking situation in that they covary with group phenomena in predictable ways.

For example, Mendelson, Mello, and co-workers have defined some of the conditions under which group interaction facilitates "spree" drinking (2), risk-taking behavior during drinking (3), and the emergence and/or suppression of psychopathology during prolonged drinking (8). Nathan and co-workers have described some of the interpersonal variables that determine choice of isolated or social drinking (6) and contribute to differences in drinking behavior, affect, and social behavior between alcoholics and nonalcoholics (7).

Both groups of researchers have also begun to systematically vary certain components of the interpersonal situation itself in an effort to focus more directly on psychosocial variables

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The authors wish to thank the staff of the Alcohol Behavior Research Laboratory, especially Ms. Mary Caruth, Head Nurse, for their cooperation, patience, and hard work, particularly during the more trying periods of this research.

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(in contrast to earlier efforts, in which these variables were incidental to the research). Thus Mendelson's group has reported on the drinking behavior of a father-son team (9) and a simulated "bottle gang" (1), while Goldman and co-workers (10) have examined some of the social influence factors that are associated with group decisions to initiate, maintain, and terminate prolonged drinking within an experimental drinking paradigm. The study on which the present paper reports represents a further effort to delineate relationships among psychosocial factors and drinking behavior in chronic alcoholic subjects.

Our decision to vary levels of interpersonal stress experimentally in this research in order to study its role as a central psychosocial influence agent during prolonged group drinking by alcoholics was made for a number of reasons. The first was our belief in the centrality of the common view that alcoholics are especially sensitive to the effects of interpersonal stress and that it therefore plays a major role in their alcoholism. Naturalistic research that touched tangentially on the role of stress in drinking by alcoholics seems to support this common view (11, 12). We were also struck by the Mendelson group's finding (1), in a study of group process among drinking alcoholics, that alcoholic subjects stopped drinking following a naturally occurring interpersonal stress event, and by Coopersmith's demonstration in 1964 (13) that alcoholics showed heightened arousal to affective communication—arousal that was subsequently lowered by self-administered alcohol. Coopersmith and Woodrow (14) subsequently showed that alcoholics demonstrate heightened arousal only to specific affective situations and that their general reactivity levels are no higher than those of nonalcoholics, concluding thereby that a relationship between stress and alcohol consumption does cohere in the chronic alcoholic.

We are also impressed by a number of coherent theories of alcoholism etiology that accord stress a central role. For example, according to Lazarus (15), whose theory of alcoholism appears to be especially well articulated, stress is at the core of alcoholism. Lazarus assumed that the alcoholic develops a conditioned association between stress and drinking, a "reflex" strengthened by the variety of social reinforcers attendant upon group

drinking (including a sense of acceptance by and recognition from alcoholic peers, dependence on the group as an antidote to boredom and loneliness, and involvement in group drinking as "social exoneration"). Thus Lazarus saw both alcohol and the group as inducers of and means of escape from stress—altogether a complex and vicious cycle.

Method

The Subjects

Three white male subjects volunteered for this research. They had all been "therapeutic failures" at the Alcohol Treatment Unit of the Veterans Administration Hospital at Lyons, N.J. All met the following selection criteria: 1) a drinking history that extended for more than five years and was characterized by prolonged episodes of spree drinking; 2) no history of neurological disease (including seizures) or of psychosis, hepatitis, or pulmonary, renal, cardiac, gastrointestinal, genitourinary, or metabolic disorders; 3) no ingestion of alcohol within two weeks of the beginning of the study; 4) no history of drug addiction; 5) no current medical treatment; 6) a positive history of alcohol withdrawal symptoms; and 7) absence of an expressed desire to stop drinking.

Demographic and drinking history data on each subject are shown in table 1. These data indicate that all subjects conformed to the Jellinek classification of "gamma" alcoholic (16).

The Setting

This research was undertaken at the Alcohol Behavior Research Laboratory (ABRL) of Rutgers University. The subject area of the ABRL contained four individual bedrooms, a dayroom, and a bar area. All bedrooms were monitored continuously by closed circuit television, and the dayroom and bar areas were under direct surveillance from an observation room via one-way windows. The bar was "tended" four hours a day—between 8 p.m. and midnight—by a male research assistant. Each bedroom was equipped with an individual operant console from which patients earned points and obtained alcohol. Each console, consisting of a wooden-framed 30-inch by 50-inch sheet of half-inch plastic, mounted a button microswitch attached to the console by a six-foot cable. Pressing the

TABLE 1
Description of Subjects' Sociocultural Background and Drinking History

SUBJECT	AGE	MARITAL STATUS	EDUCATION (GRADE)	RELIGION	OCCUPATION	DURATION OF ALCOHOLISM (YEARS)	PAST WITHDRAWAL SYMPTOMS
1	46	Divorced	8	Catholic	Cook	25	Blackouts and tremors
2	46	Single	11	Protestant	Mechanic	15	Blackouts
3	46	Separated	8	Protestant	Butcher	15	Blackouts

button microswitch repeatedly earned "reinforcement" points according to the operant schedule in force at the time.

The consoles also mounted closed-circuit television cameras and monitors, which were not used in this study, along with assorted dials, knobs, and switches that were used to provide subjects additional "interface" with the ward environment when a particular study design so required. The bar, like each console, also contained an alcohol dispenser. Adjoining the bar was the nurse's station, to which patients were brought for blood alcohol level tests and for medical attention during this study.

Procedure

This study lasted 32 days. It was divided into three major segments: a four-day pre-drinking period, a 20-day drinking period, and an eight-day postdrinking period. These three major periods were further divided into alternating two-day periods of socialization and isolation.

Socialization and isolation periods were defined by where beverage alcohol could be obtained and how reinforcement points for alcohol could be earned. During isolation, subjects worked at their operant consoles for points. Because they were restricted to their rooms during this time, they could only drink alone. During socialization, when subjects had free access to the dayroom and bar areas, alcohol was available only at the bar and points could be earned only via social interaction with other subjects.

Subjects could earn points either by social interaction or by operant responding during the predrinking period, depending on which socialization condition was in force at the time. No alcohol was available during pre-drinking, although points could buy "relief from isolation" when isolation was programmed (i.e., subjects could "buy" their way out of their rooms during isolation, at the rate of 50 points for 15 minutes in the dayroom or

bar areas). Subjects also earned points by both means during the drinking period. They could spend them during this period both for beverage alcohol and for "relief from isolation." During the postdrinking withdrawal period that concluded the study, as during predrinking, points bought "relief from isolation" but not alcohol.

Since group behavior during drinking was under investigation, a group stressor (defined as a stress imposed on all group members equally by virtue of their group membership) was imposed on the group at three discrete points during the research. To maximize the impact of the group stressor, subjects were told before the study began that their points would be added together and divided by three several times every day. As a consequence, subjects quickly came to realize that the number of points available to any of them at any given time depended on the cumulative "work" of all subjects. Subjects were also told that if group point totals reached and maintained an unspecified level by the end of the study, each would receive a cash bonus.

Two stress periods, each lasting four days, were programmed during drinking. They were separated from each other by a single four-day nonstress period. Four-day nonstress periods also began and concluded the drinking period. Another four-day stress period concluded the study. During the stress periods, subjects were told at systematic intervals that their point-earning performance had deteriorated and that, at the rate they were currently earning points, they would neither be able to continue their drinking (if the stress occurred during drinking) nor have accumulated enough points for the bonus. Conversely, subjects were told systematically during nonstress periods that they were earning points at an acceptable rate.

Both stress and nonstress messages were communicated at the beginning of each experimental period by the head nurse and then at regular intervals by the bartender. The

stress message was approximately: "We have been watching all of you carefully during the last several days and we are very disappointed with your performance. You have not been earning enough points either at your console or in social interaction. At the rate that you guys are going, you will not be able to keep drinking. You probably won't even have enough points for the bonus." The nonstress message was: "You are (now) doing well and the group is (again) working efficiently as a team with equal productivity. You are on your way to earning the bonus."

Operant Data

Subjects earned points during periods of isolation by pressing the button microswitch attached to the operant console according to a predetermined operant schedule. The schedule employed was FR 60 (60 consecutive button presses yielded one reinforcement point). In turn, 50 points were required to purchase one ounce of beverage alcohol or 15 minutes of "relief from isolation." This ratio of work to beverage alcohol was chosen because it approximates the amount of manual labor required "on the outside" to earn sufficient money to purchase equivalent quantities of beverage alcohol. The consoles continuously displayed all points given via individual electronic alpha-numeric displays (essentially miniature neon tubes shaped as arabic numbers). A computer (described below) averaged all point totals every 60 minutes.

Subjects were told that they could earn points during socialization periods by engaging in social interaction, at the rate of 20 points for 25 minutes of continuous social interaction with one other subject or for 15 minutes spent with both other subjects. Subjects were instructed to press a button on the day-room wall at the beginning of each social interaction period to "signal" the computer of their intention to socialize. The button was, in fact, nonfunctional since points were actually given according to a predetermined plan designed to heighten the effectiveness of the stressor. To this end, subjects received one-third more points during nonstress than during stress periods.

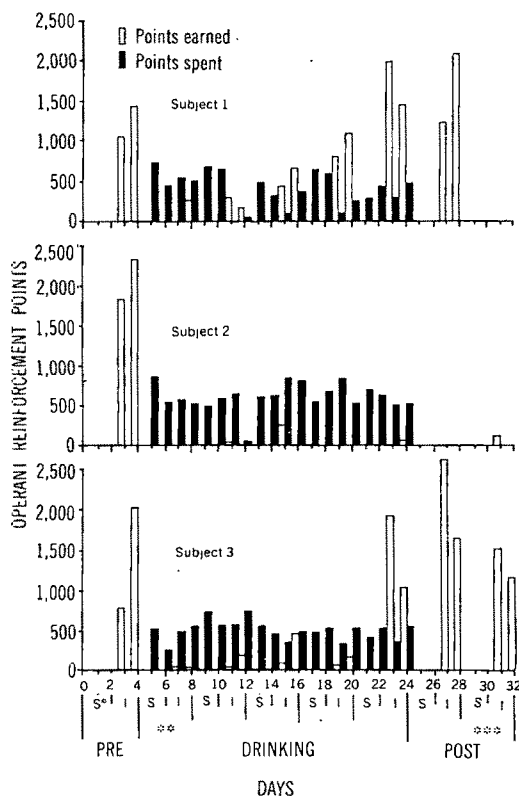
The individual operant consoles dispensed alcohol during isolation, while the group dispenser dispensed alcohol at the bar during socialization. Both dispensers gave the same amount of alcohol for the same number of

points—30 cc. of 86-proof blended whiskey for 50 points. In order to limit alcohol consumption to an amount approximately equivalent to consumption "on the street"—and to ensure against excessive consumption—the computer (a Digital Equipment Corp. PDP8/L) monitored purchases of drinks in conjunction with a "real-time" clock. These resultant computer-derived BAL readings were "updated" with periodic Breathalyzer readings that established each subject's alcohol metabolism constant. As a result, it became possible shortly after drinking began to estimate very accurately by computer each subject's blood alcohol level at any given moment. When a subject reached his preestablished blood alcohol level limit (usually 280 mg./100 ml.), the computer de-energized his drink dispenser, re-energizing it only after enough time had passed to enable his blood alcohol level to return to acceptable levels. A small red light mounted on each console signaled the temporary deactivation of the drink dispenser.

Observational Instruments

A variety of observational instruments, some especially designed for these studies, recorded data on behavior not amenable to direct operant recording. The Mood Adjective Checklist (MACL), an instrument derived from a standard psychological technique (17) and consisting of a set of Q-sort cards on which are typed adjectives descriptive of a variety of mood states, was used to assess seven self-reported mood state factors: Anxiety-Tension, Depression-Dejection, Confusion, Vigor-Activity, Anger-Hostility, Friendliness, and Fatigue-Inertia. The MACL was administered twice daily and provided subjective measures of each subject's affective response to differing blood alcohol levels, to the two social interaction conditions, and to the group stressor. The Wittenborn Psychiatric Rating Scales (WPRS) were administered at the same time each day by an advanced graduate student in clinical psychology. The WPRS, a reliable index of the kind and severity of various forms of psychopathological deviation (18, 19), consists of 72 scales, each of which taps a particular nuance of psychopathology. The measure provides cluster scores, derived from factor-analytic studies, that describe 12 general symptom patterns. The 12 labeled clusters are Anxiety, Hys-

FIGURE 1
Operant Reinforcement Points
Earned and Spent by Subjects



* Subjects worked at high operant rates to earn points during predrinking, then stopped responding altogether during the first days of drinking.

** Subjects spent approximately equivalent amounts of points for alcohol through the entire drinking period.

*** Only two subjects resumed earning points during the postdrinking period.

terical Conversion, Manic State, Depressive Total, Schizophrenic, Psychotic Belligerence, Paranoia, Hebephrenia, Obsessive-Compulsive, Intellectual Impairment, Homosexuality, and Ideas of Grandeur. A ward sociogram, which was completed hourly, was designed to reflect simply the physical distance separating one subject from another at the time of the sociogram's administration. A behavior checklist, created like the ward sociogram especially for this research, was also given hourly. It recorded the behaviors in which each subject was engaged at a certain time, along with where he engaged in them. These measures were administered by advanced graduate psychology students and nurses. Detailed nursing notes were also kept; they provided depth and dimension to the

more objective data gathered by the measures detailed above.

In addition to these observational measures, two sets of group process scales were administered several times a day. Data from these measures are reported elsewhere (20).

Physical and Physiological Measures

Blood alcohol level (BAL) readings, measured via the Breathalyzer (Model 900, Stevenson Corp., Red Bank, N.J.), were taken three times a day. They were used to "update" computer-derived levels. In addition, all BAL levels given in this paper were obtained by the Breathalyzer. Vital signs were taken three times a day, both to ensure each subject's physical health and to enable investigation of their possible covariation with the experimental procedures. An 18-item Physical Checklist (PCL), in Q-sort form, was also completed by each patient once a day throughout the course of the study. It measured the number and kind of physical complaints offered by each subject. Independent completion of the PCL by nursing personnel permitted objective comparison of subjects' and nurses' sortings. For fine-grained analysis, the PCL groups physical complaints into four separate categories: 1) complaints of gastrointestinal difficulties, 2) physical symptoms directly attributable to alcohol not subsumed within the other three groups, 3) temperature and metabolic irregularities, and 4) general systemic complaints exclusive of temperature abnormalities.

Results

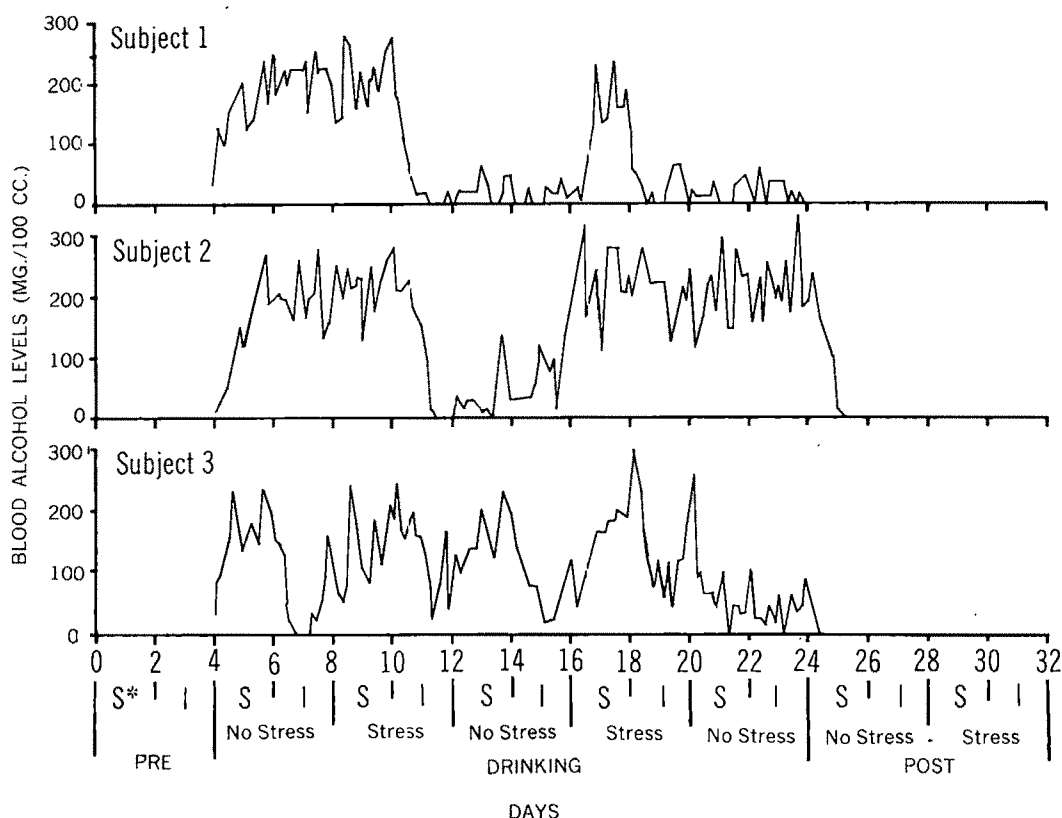
Operant Behavior

Figure 1 shows each subject's operant response rates and rates of points spent. All subjects worked at high operant levels during predrinking, then stopped responding as soon as alcohol became available. Subjects number 1 and number 3 both resumed working for reinforcement points at high rates during the final days of drinking. No systematic relationship between points earned or spent and the imposition of stress can be observed. During postdrinking, subjects number 1 and number 3 again earned points at high rates.

Drinking Behavior

Figure 1 indicates that subjects spent approximately 500 points a day for beverage al-

FIGURE 2
Range and Variability of Subjects' Blood Alcohol Levels



*All subjects peaked at levels beyond 200 mg./100 ml. during the first two days of drinking. Subjects 1 and 2 reached highest BAL levels during socialization/stress and lowest levels during isolation/stress. Subject 3 attained highest BAL levels during socialization periods and lowest levels during isolation; he thus failed to show the effect of stress shown by subjects 1 and 2.

cohol through the drinking period; subjects showed striking uniformity in this regard. Figure 2 indicates the range and variability of blood alcohol levels attained by all three subjects. As soon as alcohol became available, all subjects went on a drinking spree, a fact reflected by their extremely high BAL during the first few days of drinking. Spree drinking behavior by alcoholics during the early days of a drinking episode has been observed both in real life and in the context of previous laboratory research (5).

The BAL readings reflect both stress and social interaction effects. The average BAL of all three subjects was highest during the socialization periods. During the first stress period, two subjects maintained and one reattained high BAL readings during socialization and then, as soon as isolation/stress was imposed, lowered their rates of

drinking dramatically. All subjects stopped drinking for a time during this first isolation/stress period. Subjects 1 and 2 then continued to drink at low levels until the beginning of the second socialization/stress condition, when they again drank heavily. All three subjects peaked above 200 mg./100 ml. during the second socialization/stress period; on entering isolation/stress, all three again sharply reduced their drinking. Subjects 1 and 3 drank at reduced rates to the end of the drinking period; subject 2 maintained high BALs to that point. Superimposed on subject 3's BAL variability was an isolation effect, which was largely responsible for the apparent stress effect. Figure 2 shows that this subject sharply reduced his drinking shortly after every isolation period began and just as sharply increased his drinking on entering the socialization condition. As a result, one must

conclude that this subject did not share the apparent sensitivity of the BAL of subjects 1 and 2 both to stress and socialization but that instead, his drinking behavior reflected only the socialization variable.

Affective Behavior, Physical Symptoms, and Psychopathology

MACL data gathered throughout the study indicated that a marked change in subject 1's mood, a moderate change in subject 2's mood, and a minimal change in subject 3's mood occurred during the first stress period. The subjects reported, to varying degrees, increased levels of depression, tension, fatigue, and confusion, and decreased levels of vigor. The isolation/stress condition seemed to accelerate changes that began after socialization/stress was imposed. The second drinking/stress period yielded similar changes in mood that were, however, of lesser magnitude. Comparable mood changes were not observed during nonstress/drinking periods. During the postdrinking/stress period, all three subjects reported an increase in tension, anger, and depression; two of the three also perceived a decrease in vigor. Equivalent mood changes were not apparent during the nondrinking/nonstress period.

PCL data were very much like the MACL data in that during stress periods, especially during isolation/stress, subject 1 complained much more, subject 2 complained somewhat more, and subject 3 complained only a little more.

Repeated measures and analysis of variance statistics were used to analyze the WPRS data. They revealed that onset of drinking had a marked impact on appearance of psychopathological behavior. Five subscales of the WPRS reflected a significant increase in psychopathology as a function of drinking: Anxiety ($F=6.41$, $p<.05$); Mania ($F=6.63$, $p<.05$); Depression ($F=8.29$, $p<.05$); Schizophrenic Excitement ($F=14.91$, $p<.01$); and Intellectual Impairment ($F=8.31$, $p<.05$). These data support earlier data from this laboratory (7). Stress, however, failed to have a statistically significant effect on psychopathology.

Group Interaction

Although the several experimental variables employed in this research had a sufficiently complex effect on patterns of group in-

teraction to justify a separate report (20), it is useful to summarize a portion of these findings here because they complement the results given above. In brief, stress appeared to exert an effect on group interaction strikingly like its effect on drinking behavior, mood, and physical complaints. The onset of the first stress condition increased group interaction and involvement for a short time, during which subjects attempted to generate group enthusiasm for efforts to improve point-earning behavior. Shortly thereafter, however, when point-earning performance did not improve, subjects became less involved in the group process than they had been before stress was imposed. They withdrew to their rooms, even when the socialization condition was programmed. They drank together at the bar much less often than they had before and, when they did do so, their interaction often became quickly tinged with anger.

When the second nonstress period began, group involvement returned to "baseline"—the level of interaction that had characterized predrinking and the first nonstress drinking period. When the second stress period began, however, group behavior much like that shown during the first stress period was again observed, except that the immediate increase in group interaction was of shorter duration and the subsequent increase in group withdrawal lasted longer. Group behavior during the final drinking nonstress period again returned to increased baseline levels of interaction.

Discussion

Limits on Generalizability

Although the behavior of only three subjects was examined in this study, the fact that a number of its findings support those from studies carried out elsewhere encourages us to accept their general significance. For example, the overall pattern of drinking shown by our subjects—a weeklong spree followed by a more prolonged period of maintenance drinking—corresponds in large measure to the pattern shown by other chronic skid-row alcoholics on the street (21, 22) and in the laboratory (2, 5). In addition, all three subjects, like those in previous empirical studies (1, 6, 23), reported an increase in prevailing levels of anxiety and depression shortly after they began to drink heavily. They also

tended to become more and more isolated interpersonally as drinking continued, another finding consonant with previous research (3, 7, 22). Given these data, it seems reasonable to view this laboratory setting as analogous to other alcoholic milieus in many important essentials (if not entirely in hygiene and decor).

It should also be noted that the group stressor employed in this research—social disapproval communicated as a threat to the subjects' continued supply of alcohol—represents only one of many potential sources of stress for the chronic alcoholic. Further research with alcoholics might well focus on the differential effects of other stressors on consequent drinking behavior. Thus the effects of environmental as well as psychological stress (e.g., progressively more costly alcohol, uncomfortable and/or variable temperatures, insufficient or unpalatable food) ought to be explored in order to generate additional data relating stress to drinking that might further bridge the gap between laboratory and field reports.

Stress and the Individual

Superimposed on the cyclical pattern of drinking we have come to expect from subjects in these studies was a marked stress effect that was potentiated by concurrent isolation. It manifested itself in diverse ways: Subjects showed peak BAL readings during socialization/stress periods and lowest BAL readings during isolation/stress. They reported an increase in tension, fatigue, confusion, and depression and a decrease in vigor during stress periods; these changes in mood were most pronounced during isolation/stress. Subjects reported more somatic complaints during stress than nonstress periods, and more during isolation/stress than socialization/stress. Group interaction during stress increased as soon as stress was imposed, then decreased when it became apparent that point-earning behavior was not increasing despite group exhortation.

Before dealing with the complex issue of interactions among stress, drinking behavior, mood, and social behavior, we must consider a curious anomaly in our data. Despite the fact that all subjects showed the effects of stress, isolation, or both on BAL readings, none showed equivalent effects on point-spending behavior, even though point spend-

ing and BAL ought to have been closely related. That is, although subjects drank more during socialization periods, especially socialization/stress periods, they purchased approximately equal amounts of beverage alcohol across all experimental periods. For example, although subject 2 purchased no more alcohol on days 6 and 7 than on days 13 and 14, his BAL on days 6 and 7 averaged over 200 mg./100 ml., while his BAL on days 13 and 14 averaged approximately 50 mg./100 ml. Three distinct behavioral observations explain this paradox: 1) subjects "hoarded" beverage alcohol purchased during isolation, which they later drank during socialization, especially socialization/stress periods; 2) subjects shared, spilled, and occasionally threw away alcohol during nonstress periods; and 3) subjects drank in more concentrated fashion when the bar was "open" during socialization, especially in socialization/stress periods, and they spaced their fewer drinks throughout the day during periods of isolation.

Though these observations explain the differences in BAL over different study periods, we must still try to understand our subjects' decisions to purchase beverage alcohol they did not drink, especially during isolation/stress. We think the most parsimonious way to do so is to view this behavior as a learned response. That is, our subjects may well have learned to purchase alcohol in the midst of prolonged drinking episodes irrespective of their immediate desire to drink it. Alcoholics report in clinical interviews the prepotent need to have a ready and secure supply of alcohol during a spree, even though they may have temporarily stopped drinking in the midst of one. Hence it appears that at least two schedules of reinforcement might be involved in chronic drinking—an acquiring schedule and a consuming schedule. This conclusion accords with Keehn's view (24) that alcoholism is controlled by multiple schedules of reinforcement, so that in order to treat the alcoholic successfully, one must discover the various schedules of reinforcement that maintain his behavior. Behavioral treatment programs fall short, Keehn felt, when they try only to terminate drinking without confronting the other elements of the drinking situation that reinforce the alcoholic. In the situation of our study, for example, efforts to extinguish our subjects' drinking would have

failed if the alcohol-acquisitive behavior, which seemed to function in large part independently of drinking behavior, had been ignored.

Stress and the Group

The complex relationship that emerged in this study linking social interaction, stress, mood, and drinking behavior sheds some light on the conflicting findings of Mendelson and Mello (4) and Nathan and his co-workers (5)—a conflict similarly unresolved within the broader alcoholism literature—as to whether the skid-row alcoholic is primarily a social drinker or an isolated drinker.

Data from the present research indicate, to begin with, that the stress condition we imposed had a differential effect on the behavior of our three subjects. Stress had its most marked effect on subject 1, whose drinking behavior, mood, group behavior, and frequency of physical complaints changed markedly with the onset of stress. Stress had a moderate effect on these indices of subject 2's behavior, while it seemed to have little or no effect on subject 3's drinking behavior and had minimal effect on his mood and involvement with the group. Superimposed on these stress effects were the effects of isolation, in response to which subjects also differed markedly. Thus subject 3 showed a pronounced effect of isolation in his BAL during both stress and nonstress periods, while subjects 1 and 2 were affected by isolation only when it was programmed as isolation/stress. The fact that drinking itself also exerted a pronounced overall effect on mood, group interaction, and psychopathology completes our portrayal of the determinants of this relationship.

When one attempts to bring some order to this welter of observations, one is forced to conclude that the determinants of social versus isolated drinking probably include some heretofore unrecognized variables, among which are the amount and temporal distribution of the drinking that is programmed, the individual drinking histories of the members of the drinking group, and each subject's characteristic affective reaction to group drinking and group stress. Hence, we must conclude that attempts to rationalize the choice of social or isolated drinking that do not include consideration of these factors would seem, given our data, to be doomed to

inconclusiveness, especially when they fail to acknowledge that stress alone or isolation alone does not affect mood or drinking behavior to the extent that the two together probably do.

We must also attempt to explain the fact that our subjects failed to purchase relief from isolation, especially during isolation/stress, even though they were most uncomfortable during these times. A similar question might be asked of chronic alcoholics in the natural setting, who often say they prefer to drink with others but invariably report substantial periods of isolated drinking during a spree. Our subjects based their refusal to spend points for relief from isolation on two major factors: 1) they did not wish to risk depleting their store of points before the drinking period ended; and 2) they found themselves becoming increasingly irritable as drinking proceeded and so wished to avoid angry confrontations with their fellows. Similar mechanisms may be operable on the street. Alcoholics report that solitary drinking, despite its drawbacks, reduces the risk of arrest for public drunkenness or the theft of "drinking money" or the bottle, all of which would necessitate their premature withdrawal from alcohol. Chronic alcoholics less often rationalize isolated drinking as a function of mood changes over the course of a drinking episode, although one must assume that these changes might also play a role on the street akin to the one they played in this laboratory.

The Etiology of Alcoholism

These data would seem to permit an empirically based reply to the several theories of the etiology of alcoholism that accord stress a central role. The findings of the present study suggest that a portrayal of the relationship between stress and drinking as a direct function is overly simplistic. They suggest, instead, that the interpersonal stress we imposed increased the rate of drinking (for two of three alcoholic subjects) during periods of socialization but decreased it during periods of isolation. These changes in drinking rate occurred independently of changes in mood, since the rate of drinking and levels of anxiety and depression both increased during socialization/stress but moved in opposite directions during isolation/stress (when the rate of drinking slowed markedly and anxiety and depression continued to increase). The effect

of stress on drinking behavior thus might be considered a function of at least the following: 1) whether the subject is a "stress responder" to begin with; 2) whether the stress is interpersonal or environmental; and 3) whether it is imposed in the context of social or isolated drinking.

REFERENCES

- Mendelson JH, Mello NK, Solomon P: Small group drinking behavior: an experimental study of chronic alcoholics. *Res Publ Ass Res Nerv Ment Dis* 46:339-430, 1968
- Mello NK, Mendelson JH: The effects of prolonged alcohol ingestion on the eating, drinking, and smoking patterns of chronic alcoholics, in *Learning Mechanisms in Smoking*. Edited by Hunt WA. Chicago, Aldine, 1970, pp 207-208
- Mello NK, McNamee HB, Mendelson JH: Drinking patterns of chronic alcoholics: gambling and motivation for alcohol. *Psychiatric Research Report no 24*. Washington, DC, American Psychiatric Association, 1968, pp 71-82
- Mendelson JH, Mello NK: Experimental analysis of drinking behavior of chronic alcoholics. *Ann NY Acad Sci* 133:828-845, 1966
- Nathan PE, Titler NA, Lowenstein LM, et al: Behavioral analysis of chronic alcoholism. *Arch Gen Psychiat* 22:419-430, 1970
- Nathan PE, O'Brien JS, Lowenstein LM: Operant studies of chronic alcoholism: interaction of alcohol and alcoholics, in *Biological Aspects of Alcohol*. Edited by Creaven PJ, Roach MK. Austin, University of Texas Press, 1971, pp 341-370
- Nathan PE, O'Brien JS: An experimental analysis of the behavior of alcoholics and nonalcoholics during prolonged experimental drinking. *Behav Ther* 2:455-476, 1971
- Tamerin JS, Mendelson JH: The psychodynamics of chronic inebriation: observations of alcoholics during the process of drinking in an experimental group setting. *Amer J Psychiat* 125:886-895, 1969
- Weiner S, Tamerin JS, Steinglass P, et al: Familial patterns in chronic alcoholism: a study of a father and son during experimental intoxication. *Amer J Psychiat* 127:1646-1651, 1971
- Goldman MS, Taylor HA, Carruth ML, et al: To drink or not to drink: an experimental analysis of the effects of group decision making on group drinking by alcoholics. *Quart J Stud Alcohol*, 1972 (in press)
- Isbell H, Fraser HF, Wikler A: An experimental study of the etiology of "rum fits" and delirium tremens. *Quart J Stud Alcohol* 16:1-33, 1955
- Zwerling I: Psychiatric findings in an interdisciplinary study of 46 alcoholic patients. *Quart J Stud Alcohol* 20:543-554, 1959
- Coopersmith S: The effects of alcohol on reactions to affective stimuli. *Quart J Stud Alcohol* 25:459-475, 1964
- Coopersmith S, Woodrow K: Basal conductance levels of normals and alcoholics. *Quart J Stud Alcohol* 28:27-32, 1967
- Lazarus AA: Toward the understanding and effective treatment of alcoholism. *S Afr Med J* 39:736-741, 1965
- Jellinek EM: *The Disease Concept of Alcoholism*. Highland Park, NJ, Hillhouse Press, 1960
- McNair DM, Lorr M: An analysis of mood in neurotics. *Journal of Abnormal and Social Psychology* 69:620-627, 1964
- Wittenborn JR: *Wittenborn Psychiatric Rating Scales*. New York, Psychological Corp, 1955
- Wittenborn JR: *Manual for the WPRS: Preliminary Draft*. New Brunswick, NJ, Rutgers University, 1968
- Allman LR: Group drinking during stress: effects on alcohol intake and group process. *Int J Addict*, 1972 (in press)
- Wallace S: *Skid Row as a Way of Life*. Totawa, NJ, Bedminister Press, 1968
- Rubington E: The bottle gang. *Quart J Stud Alcohol* 29:943-955, 1968
- Mayfield D, Allen D: Alcohol and affect: a psychopharmacological study. *Amer J Psychiat* 123:1346-1354, 1967
- Keehn JD: Reinforcement of alcoholism: schedule control of solitary drinking. *Quart J Stud Alcohol* 31:28-39, 1970

Depression During Mania: Clinical Observations and Theoretical Implications

BY JOEL KOTIN, M.D., AND FREDERICK K. GOODWIN, M.D.

In the course of longitudinal studies of patients with manic-depressive illness, the authors regularly observed clear features of depression during periods of acute mania. The relationship of depression to mania in 20 hospitalized patients was systematically investigated through an analysis of nurses' and physicians' behavioral ratings and notes. Statistically significant positive associations between mania and depression were found in the majority of cases. The psychological implications of the concurrent presence of depression and mania are discussed.

SINCE THE EARLY observations of Kraepelin (1), several studies of manic-depressive patients have commented on the occurrence of depression or depressive affect during episodes of mania (2-4). Over the last ten years, more than 70 manic inpatients have been studied longitudinally by our research group at the NIMH. During this time we and our colleagues have repeatedly observed clear features of depression occurring during manic episodes in the majority of patients (5-7). These clinical observations seem to be inconsistent with the standard view of mania and depression as "opposite" states—a view that

is not only expressed in virtually every textbook description of mania and depression, but is also implicit in some formulations concerning biological factors in depression and mania (8).

Thus, Redlich and Freedman (9) described mania as "a mirror of depression . . . the basic affect is the euphoric state of mind; in its purest form these patients feel happy, unconcerned, free of worry." Cohen (10) noted that "the manic patient characteristically displays elation or irritability, pressure of speech, flight of ideas, and increased motor activity. The depressive patient displays the converse: depressed mood, mental and motor retardation, and sometimes feelings of agitation and apprehension (10, p. 676). Most textbook descriptions refer to "mixed states" in which depression and mania can occur together, but this is generally considered unusual.¹

The purpose of the present study was to conduct a more systematic investigation of the relation of depression to mania by analyzing ratings for mania and depression in 20 manic patients consecutively admitted to two research wards at the NIMH. In addition, therapists' notes, nurses' observations, and patients' quotes recorded during manic periods were analyzed for depressive content.

Method

All patients had been hospitalized for mania or for depression on one of two metabolic research units at the clinical facilities of the NIMH in Bethesda, Md. Prior to admission, patients were interviewed by two

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1-5, 1972.

At the time this paper was written, the authors were both with the Section on Psychiatry, Laboratory of Clinical Science, National Institute of Mental Health, Bethesda, Md., where Dr. Kotin was Clinical Associate and Dr. Goodwin is Chief, Clinical Research Unit. Dr. Kotin is now Assistant Adjunct Professor of Psychiatry, Department of Psychiatry and Human Behavior, University of California at Irvine, and Assistant Chief, Crisis Intervention Center and Outpatient Department, Orange County Medical Center, 101 City Dr. South, Orange, Calif. 92668. Address reprint requests to Dr. Kotin at the Orange County Medical Center.

The authors wish to thank Mr. Martin W. Matzen and Dr. James Dent for their assistance in statistical analysis of the data.

¹ Winokur and associates (11) noted that depressed periods lasting from several minutes to several days occurred in 68 percent of 100 manic episodes observed in hospitalized patients; however, they distinguished these manic episodes from "mixed states," which occurred in a minority of patients.

psychiatrists and a social worker and a diagnosis was established at that time, confirmed by information from the family and the referring physician, reports of previous hospitalizations, and psychological testing. Any patient who had current symptoms or a history suggestive of schizophrenia was excluded from the study. In establishing the diagnosis of mania or depression, we employed the criteria for primary affective disorder described by Winokur, Clayton, and Reich (11). If observations during the course of hospitalization (averaging four months) raised any questions about the initial diagnosis of affective illness, the patient was excluded from the study.

Throughout the course of hospitalization each patient was individually rated by a nursing research team at least twice daily. Each member of the nursing team rated each patient from 1 to 15 on a multi-item scale designed for the evaluation of depression and mania (7, 12, 13). The instructions used by the nurses are reproduced in Appendix 1. After the individual ratings were accomplished independently, the nursing team discussed them and a consensus rating was worked out for each patient on five global items: depression, mania, anger, psychosis, and anxiety. A staff-patient ratio of better than 1:1 makes it possible to conduct intensive ratings of this kind. Interrater reliability has been consistently high with this rating system. Psychiatrists' ratings were done independently two to five times per week as a check on the validity of the nurses' ratings.

Twenty patients (ten from each unit) were selected on the basis of having had definite episodes of mania during their hospitalization. A manic episode was defined as a period of at least three consecutive days during which the consensus global rating for mania was 5 or greater when the day and evening ratings were averaged. Fifteen patients were manic on admission and five were depressed. This sample included 12 women and eight men with an age range from 22 to 51 (median = 42).

Using Kendall's tau as a measure of association, we analyzed the mean daily mania and depression ratings (the nurses' consensus ratings) for each patient during all manic episodes and during the entire hospital course. (Tau is more suitable to our data than Pearson's r since it is more accurate with small numbers of classes and does not assume lin-

earity between classes.³) We also compared ratings changes from day to day (increase, no change, or decrease) for depression and mania for each patient and analyzed the totals according to a chi-square distribution. Finally, we compared the mean depression ratings during manic and nonmanic periods, evaluating significance by t test.

Results

Considering only the period of the manic episode, 13 of the 20 patients had significant positive correlations between mania and depression ratings (Kendall's tau, $p < .01$). Only two patients had significant negative correlations.

Similar findings emerge from analysis of the entire hospital course, which includes periods of depression without mania for most patients. Thirteen patients had significant positive correlations; three patients had significant negative correlations ($p < .01$).

The analysis of changes in daily ratings also yielded similar results. For the majority of patients, on any given day, mania and depression ratings were significantly more likely to change in the same direction than in opposite directions ($p < .05$ by chi square).

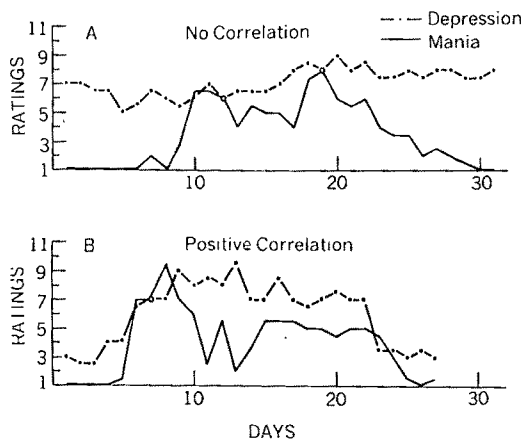
For ten patients the mean depression rating was significantly *higher* during the manic episode than during nonmanic (depressed) periods in the hospital, while for three patients the mean depression rating was significantly *lower* during the manic period ($p < .05$ by t test).

To rule out any possible effect of drugs on the data, we analyzed the mania and depression ratings during all drug-free manic periods lasting at least 20 days. Of the nine patients in our sample who had such periods, five had significant positive correlations between mania and depression ratings during these intervals ($p < .01$ by tau), while none showed a significant negative correlation. Thus, the presence or absence of psychoactive drugs did not seem to alter the relationship between mania and depression ratings.

In order to evaluate the possibility that rating styles idiosyncratic to one unit were

³ In this context, each rating value comprises a class, i.e., there is a theoretical total of 15 classes. In practice, however, the extreme ends of the rating scale tend not to be used; thus the number of classes is generally less than ten.

FIGURE 1
"No Correlation" and "Positive Correlation" in the
Relationship Between Mania and Depression



weighting the results, the data for each unit were analyzed separately. Despite the fact that the nursing teams in the two units function independently and receive their rating training from different groups of psychiatrists, the relationship between mania and depression ratings in the two wards was found to be similar.

Figures 1 and 2 illustrate some of the various combinations of changes in mania and depression ratings we have observed. Part A of figure 1 illustrates a brief manic episode during a near-constant level of depression, while part B shows a patient with a positive correlation between mania and depression, which is representative of the majority of our patients. Figure 2 illustrates two instances of decreasing depression ratings during increasing mania—the "classical" inverse relationship. This variety of changes reflects our nursing staff's ability to rate each syndrome separately.

The "feel" of the coexisting depression and mania can best be communicated through examples. The two case reports presented here are illustrative.

Case Reports

Case 1. F is a 30-year-old unmarried Jewish woman referred to the NIMH because, according to her mother, "she was starting to become hyperactive."

The patient is the older of two daughters. When she was eight and a half, her father, to whom she

felt close, died of a sudden coronary thrombosis in the patient's presence.

At age 13 she was admitted to a university psychiatric hospital for a behavior disorder and over the next three years had four more admissions, two for mania and two for depression. Notes from her therapist at that time state: "Previously a rather reserved, quiet child, she began to be loud, inappropriate, laughing and singing, telling rather vulgar stories, wandering about her apartment house at night and, on several occasions, made raids on the refrigerators of nearby apartments, eating what she pleased without permission."

Over the next 14 years, the patient had approximately six more hospitalizations at a state hospital, each lasting two to six months. Most of the admissions were for mania, which was usually followed by a period of depression. She received two courses of ECT and was treated with numerous medications, including phenothiazines and antidepressants. At the time of her admission to NIMH, the patient lived with her mother and was receiving 25 mg. of amitriptyline and 2 mg. of diazepam three times a day.

On admission, F appeared slightly disheveled and wore no makeup. She was alert and well oriented. She talked rapidly. Her mood was slightly euphoric, but she appeared somewhat anxious. Her affect was labile. She had some flight of ideas but no delusions or hallucinations. Judgment and insight were slightly impaired, but she made it clear that she wanted treatment with lithium and wanted to leave home and her mother, who she felt used her, preyed on her guilt, and would not let her have a life of her own. Her diagnosis on admission was manic-depressive illness, hypomanic phase.

FIGURE 2
Two Examples of Negative Correlation Between
Mania and Depression

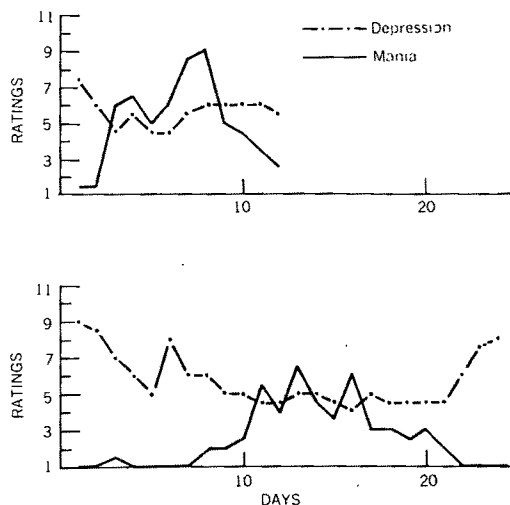
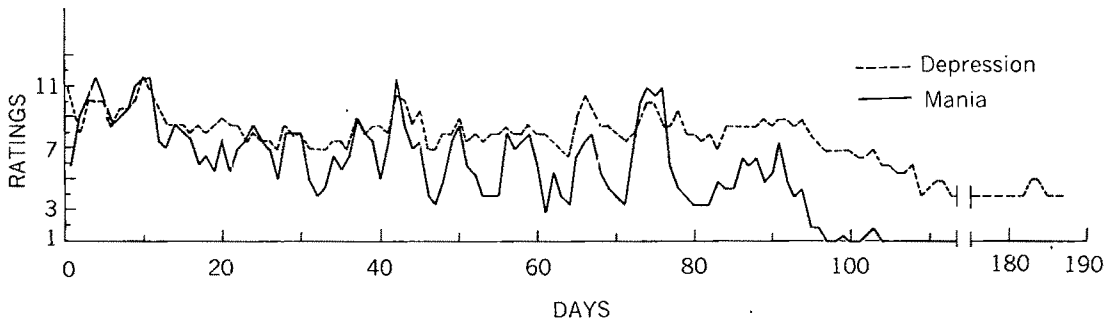


FIGURE 3
Mania and Depression Ratings During the Hospital Course of Patient F



F's mania escalated rapidly, as the following excerpts from the nursing notes for the first few days of hospitalization indicate. The behavioral ratings for mania and depression for the eight-hour period described follow each quote.

Day 3: Increased motor activity, hyperverbal, loud, unable to accept limits set on her. Crying and showing poor impulse control; also irritable and depressed; said, "I just don't have anything to live for anymore." At one point, earlier in the night, when she attempted to go to sleep, she told the nurse she tried to smother herself but "just couldn't go through with it." (mania = 10, depression = 10)

Day 4: Has been awake and up entire night. Hyperverbal, hyperactive, manipulative, threatening harm to self and others, talks with flight of ideas and with a great deal of sexual connotation. Screamed and yelled, becoming combative, threatening to set fire to self with her cigarettes and matches in effort to have her doctor come and talk with her. (mania = 11, depression = 10)

A week after admission, the patient was frequently in seclusion and required one-to-one nursing care. In the midst of severely manic behavior (hyperactive, hyperverbal, intrusive) she would talk of suicide, as illustrated in these excerpts.

Day 9: Demands attention and favors constantly. Placed in seclusion room for short time because she was hitting people, lashing out at men today more than at women. While in seclusion she said, "I'm going to kill myself, and then you'll be sorry. I'd rather be dead than crazy." (mania = 11, depression = 9)

Day 10: Requiring close observation due to disruptive, agitated behavior. Abusive language; content often sexual, in Yiddish, and containing threats. Very demanding, attention seeking, and disorganized. Provocative to other patients and staff. Made suicide attempt while in seclusion by wrapping bra tightly around neck. (mania = 11, depression = 11)

During the next three months, F remained manic despite intermittent treatment with a number of experimental therapeutic agents. Her level of mania fluctuated between ratings of 3 and 11, while her depression ratings varied from 6 to 10. The highest depression ratings were those during periods of manic escalation (see figure 3). The following quotations from nursing notes further illustrate depressive features during F's mania.

Day 43: Remains hyperverbal, manipulative, and demanding, but depicts feeling of rejection and hopelessness. One episode of crying, "No one cares about me; I have to care about myself." (mania = 8, depression = 10)

Day 74: Has been hyperverbal all evening with much pressure of speech. Had several angry outbursts and had to be sent to her room to calm down. Covered her face, hair, and hands with food coloring. Refused her medications and was verbally abusive. Many mood changes in short period of time. Crying because today was the day her father died many years ago, and the next minute laughing about her mother. Was extremely demanding most of the evening. Responding to limits was only fair. (mania = 11, depression = 10)

Day 86: Becoming increasingly manic. Talking constantly, exhibiting much pressure of speech, irritable, demanding, and manipulative. Says frequently, "I can't stop talking." Appears physically exhausted and pale. Tearful at times when she complains of feeling "confused." (mania = 6, depression = 8)

In response to a combination of lithium carbonate and chlorpromazine, F's mania finally subsided. She remained moderately depressed but never so severely as during her manic periods. Her maximum depression rating in the postmanic period was 8, with an average of about 6 for the two months immediately following the cessation of mania. She was tapered off chlorpromazine and continued to improve slowly. Her depression manifested itself primarily as lethargy without severe hopeless or guilty feelings. At the time of her dis-

charge her depression ratings had declined to 3.

Case 2. S, a 21-year-old college student, the oldest and most successful of three children, had experienced her first psychiatric difficulty two years prior to admission, with the development of a moderate retarded depression that lasted about three months. Several months later she became hyperactive, angry, argumentative, and intrusive, progressing to the point that she evidenced pressure of speech, flight of ideas, rhyming and punning, and increasingly severe outbursts of anger accompanied by physical aggressiveness, leading to hospitalization and treatment with large doses of phenothiazines. A subsequent depression several months later was treated successfully with imipramine. The onset of a second manic episode precipitated her admission to NIMH. On the ward she talked and moved about incessantly, intruding indiscriminately in the affairs of others. Her verbal productions were too rapid to be recorded in detail and her thought content was grandiose, paranoid, angry, and filled with sexual themes, interspersed with considerable depressive content.

The following excerpts are taken from detailed notes based on daily psychiatric interviews with this patient during a period of escalating mania. In this case, it can be seen that the depressive elements began to appear as the patient's mania increased in severity. During her hypomanic phase, little depression was evident.

Day 21: Patient comes in humming, singing, with occasional silly laughter, perhaps talking a bit fast; reads from a prepared statement in a somewhat grandiose way. (mania = 3, depression = 3)

Day 24: Alternately lighthearted and depressed, with mildly grandiose hypomanic and at times tentative paranoid ideation. Some push of speech . . . she describes her brain as "going too fast. . . I've been thinking so many things that I feel exhausted. I think so much I can't even sleep." In the midst of grandiose and confident statements she gave the suicidal message: "I felt so low last night that if someone had given me a knife or gun—pow. I have to cover my depression. That's part of the reasons why I can't sleep." (mania = 7, depression = 8)

Day 25: Patient brings paraphernalia into the interview room with her for the first time. Associations seem somewhat looser and involve frequent seductive references. Amidst grandiose and threatening remarks, she acknowledged that she "felt like nothing—nobody notices me—I'm nobody. . . If I can live through one minute today then I know I'm sane. . . The President came across the ward to see me today. All the people in the country know me." (mania = 10, depression = 10)

Day 29: Patient enters the interview room

dressed inappropriately, with a flower in her hair. Brings pillows with her. Paces about the room, occasionally making threatening gestures toward the interviewer. Her thinking pattern was very loose, psychotic, and grandiose; for the first time her associative pattern was riddled with clanging, rhyming, and punning. There were frequent outbursts of crying, mixed with statements of despair and suicidal messages. (mania = 13, depression = 12)

The following excerpt, taken from a subsequent period in her hospitalization after recovery from the manic episode, is revealing.

Day 46: "My high mood is like a rushing up of excess energy and becoming extra active in order to lift myself out of depression. Depression is really the basic mood and the highness is a cover . . . a holding operation. I've always been so afraid of people knowing what I'm really thinking or feeling. I haven't wanted anyone to know I'm depressed because I have no reason to be depressed and I was ashamed of it."

This patient evidenced a clear antimanic response to lithium and has been maintained on this drug for a period of five years. During this time she has not experienced either depressive or manic episodes. She returned to college and was married after graduation; she recently gave birth to her first child.

Discussion

Our data indicate that ratable depression occurred during manic periods in each of the 20 hospitalized manic-depressive patients studied. Furthermore, mania and depression ratings correlated positively in a majority of patients.³ This was true for both the manic periods and for the entire hospital courses of our patients. These findings are contrary to the common view that a patient is either manic or depressed. Our clinical examples are intended to show that the concurrent mania and depression ratings are not artifactual—they are not simply the result of rapidly alternating moods or cross-contamination from another parameter, such as agitation in depression being called mania. It is important to note that, in a number of instances, the nurses' ratings for depression did go down as mania

³ The significance of the tau values requires some qualification. Such factors as the possible interdependence between one day's ratings and the next's may bias the correlation. Partly to compensate for this, we accepted $p < .01$ as our level of significance. The important point, however, is that mania and depression ratings clearly correlated positively rather than negatively in 13 out of the 20 manic patients.

went up (negative correlation), a fact that indicates that the nurses were capable of rating mania without rating depression.

Although euphoria is often said to be the hallmark of mania, we found that it was sometimes absent when patients were depressed and manic at the same time. In these instances mania was nevertheless clearly identifiable by pressure of speech, increased motor activity, anger, intrusiveness, grandiosity, and mood instability. Depression during mania was frequently evidenced by expressed feelings of helplessness and hopelessness and thoughts of suicide. Sleep disturbance, irritability, anorexia, and many other symptoms are common to both conditions.

The possibility that subtypes of mania exist has been raised by Beigel and Murphy (7), who studied a similar group of 12 patients and found that two-thirds of the manic patients had high scores on items rating elation and grandiosity, while the other third had high scores on items rating paranoia and destructiveness. These authors noted that ten out of the 12 patients had ratable depression during manic periods. Although depressive elements were evident in both groups, it appeared from their data that depression was more predominant in the paranoia-destructiveness subgroup.

One important question is whether our sample of 20 patients is representative of the overall population of manic patients. First, great care was taken to screen out individuals with either a history or present symptoms suggestive of schizophrenia or schizoaffective disorder. Although clinical judgment is not always precise in this area, the fact that the diagnosis was arrived at independently by two psychiatrists after observing the patient throughout an entire hospitalization makes diagnostic imprecision less likely.

Patients admitted to NIMH for mania tend to show symptoms in the moderately severe to severe range; the sample may thus represent individuals with a more severe form of the illness than the "average" manic-depressive. This potential bias of our sample toward the more severe end of the continuum must be taken into account when interpreting our data. In this regard, it is our clinical impression that patients with milder forms of mania (hypomania) do not show as frequent or clear depressive features as this sample. Some specific factors may also have affected the rela-

tionship between mania and depression in our patients, such as prolonged hospitalization, a therapeutic milieu designed to control manic behavior, and the withholding of immediate treatment for research purposes.

The finding that patients are manic and depressed at the same time is consistent with most psychological theories of mania. Lewin's view (14, 15) that mania and depression are both forms of defense against anxiety is compatible with the possibility that aspects of both defensive patterns may be present simultaneously. Freud (16) and Abraham (17) both concluded that mania and depression are dominated by the same complexes. The view that mania is a defense against depression has been espoused by Klein (18, 19) and Cohen and associates (4). Our data suggest that if mania is a defense against depression, it is often an inadequate defense, since depressive symptoms can remain prominent during the manic phase. On the other hand, the observation that manic-depressive patients tend to have less severe depressions and lower suicide rates than patients who have depressions only (20) supports the idea that mania may be protective, as Cohen and associates suggested (4).

The relationship between mania and depression has important implications for psychobiological theories of affective illness. For example, the biogenic amine hypotheses of affective disorders, based primarily on pharmacological data, propose that depression is associated with decreased levels of functional neurotransmitter amines at certain critical central nerve endings while, conversely, mania is associated with elevated levels of functional amines (8, 21, 22). Thus, these theories conceive of mania and depression as representing opposite poles of a single biochemical continuum.

On the other hand, the reported electrolyte abnormalities (23), as well as certain neurophysiological parameters in affective illness (24), have been reported to deviate from normal in the same direction in mania and depression. Furthermore, some drugs, such as cortisone, can precipitate episodes of either depression or mania—sometimes in the same individual (25). In addition, lithium has been reported to have some therapeutic efficacy prophylactically (26) and acutely (6) in depression as well as in mania. Thus, data of this kind would better fit a continuum model,

as proposed by Court (27), or a triangular model, as proposed by Whybrow and Mendels (24).

An adequate model for manic-depressive illness should account not only for those aspects of mania and depression which are "opposite" but also for those which are similar in the two states. It would appear that the level of psychomotor activity clearly varies in an "up-down" fashion in mania and depression⁴; on the basis of our clinical studies with catecholamine precursors (28) and synthesis inhibitors (29) we have hypothesized (30) that the level of psychomotor activity is the aspect of affective illness most directly related to brain catecholamine function.

On the other hand, the essential cognitive and mood components of affective illness may be largely the clinical reflections of an underlying biological dysfunction common to both clinical states and only indirectly related to amine function. In this context, mania might be viewed as a process that can occur in addition to an ongoing depression, coexisting with it rather than replacing it.

⁴ In our experience the psychomotor state of manic-depressive (bipolar) patients in the depressive phase is virtually always retarded rather than agitated.

REFERENCES

1. Kraepelin E: Manic-Depressive Insanity and Paranoia. Edinburgh, E & S Livingston, 1921
2. Rennie TAC: Prognosis in manic-depressive psychoses. *Amer J Psychiat* 98:801-814, 1942
3. Blank HR: Depression, hypomania and depersonalization. *Psychoanal Quart* 23:20-37, 1954
4. Cohen MB, Baker G, Cohen RA, et al: An intensive study of twelve cases of manic-depressive psychosis. *Psychiatry* 17:103-138, 1954
5. Bunney WE Jr, Goodwin FK, Davis JM, et al: A behavioral-biochemical study of lithium treatment. *Amer J Psychiat* 125:499-512, 1968
6. Goodwin FK, Murphy DL, Bunney WE Jr: Lithium carbonate treatment in depression and mania. *Arch Gen Psychiat* 21:486-496, 1969
7. Beigel A, Murphy DL: Assessing clinical characteristics of the manic state. *Amer J Psychiat* 128:688-694, 1971
8. Schildkraut JJ: The catecholamine hypothesis of affective disorders: a review of supporting evidence. *Amer J Psychiat* 122:509-522, 1965
9. Redlich FC, Freedman DX: The Theory and Practice of Psychiatry. New York, Basic Books, 1966, p 536
10. Cohen RA: Manic-depressive reactions, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins, 1967, pp 676-688
11. Winokur G, Clayton PJ, Reich T: Manic-Depressive Illness. St Louis, CV Mosby Co, 1969
12. Bunney WE Jr, Hamburg DA: Methods for reliable longitudinal observation of behavior. *Arch Gen Psychiat* 9:280-294, 1963
13. Beigel A, Murphy DL, Bunney WE Jr: The manic-state rating scale: scale construction, reliability, and validity. *Arch Gen Psychiat* 25:256-262, 1971
14. Lewin BD: The Psychoanalysis of Elation. New York, WW Norton & Co, 1950
15. Lewin BD: Some psychoanalytic ideas applied to elation and depression. *Amer J Psychiat* 116:38-43, 1959
16. Freud S: Mourning and melancholia (1917), in The Complete Psychological Works, standard ed, vol 14. Edited by Strachey J. London, Hogarth Press, 1955, pp 237-259
17. Abraham K: Notes on the psychoanalytical investigation and treatment of manic-depressive insanity and allied conditions, in Selected Papers. By Abraham K. New York, Basic Books, 1953, pp 137-156
18. Klein M: Contributions to Psychoanalysis: 1921-1945. London, Hogarth Press, 1948
19. Segal H: Introduction to the Work of Melanie Klein. New York, Basic Books, 1964
20. Dunner DL, Gershon ES, Goodwin FK: Heritable factors in affective illness. Read at the 123rd annual meeting of the American Psychiatric Association, San Francisco, Calif, May 11-15, 1970
21. Bunney WE Jr, Davis JM: Norepinephrine in depressive reactions. *Arch Gen Psychiat* 13:483-493, 1965
22. Lapin TP, Oxenkrug GF: Intensification of the central serotonergic processes as a possible determinant of the thymoleptic effect. *Lancet* 1:132-136, 1969
23. Coppen A: The biochemistry of affective disorders. *Brit J Psychiat* 113:1237-1264, 1967
24. Whybrow PC, Mendels J: Toward a biology of depression: some suggestions from neuropsychology. *Amer J Psychiat* 125:1491-1500, 1969
25. Fawcett JA, Bunney WE Jr: Pituitary adrenal function and depression. *Arch Gen Psychiat* 16:517-535, 1967
26. Bastrup PC, Schou M: Lithium as a prophylactic agent: its effect against recurrent depressions and manic-depressive psychosis. *Arch Gen Psychiat* 16:162-172, 1967
27. Court JH: Manic-depressive psychosis: an alternative conceptual model. *Brit J Psychiat* 114:1523-1530, 1968
28. Goodwin FK, Murphy DL, Brodie HKH, et al: L-dopa, catecholamines, and behavior: a clinical and biochemical study in depressed patients. *Biol Psychiat* 2:341-366, 1970
29. Brodie HKH, Murphy DL, Goodwin FK, et al: Catecholamines and mania: the effect of alpha-methyl-para-tyrosine on manic behavior and catecholamine metabolism. *Clin Pharmacol Ther* 12:218-224, 1971
30. Bunney WE Jr, Goodwin FK, Murphy DL: Theoretical implications of the switch process. *Arch Gen Psychiat* 27:312-317, 1972

APPENDIX 1

Nurses' Instructions for Rating Mania and Depression

Depression—rate from 1 to 15, considering each of

the following:

- A. Feelings of hopelessness and helplessness.
- B. Feelings of worthlessness and guilt.
- C. Concern with death or suicide.
- D. Psychomotor activity:
 - 1. Retardation—slowed speech and movement, low monotonous voice, lack of interest in surroundings—or
 - 2. Agitation—nervous, stereotyped, repetitive hyperactivity, such as hand-wringing, pacing. (Agitation in depressed patients is also a manifestation of anxiety and may therefore raise both ratings; agitation by itself does not imply mania.)
- E. Depressed appearance, including sad expression, crying, drabness in dress and makeup.
- F. For some persons: physical complaints, loss of appetite, sleep disturbance.

Mania—rate from 1 to 15, considering each of the following:

- A. Mood—classically “elated but unstable”; however, some persons may show a predominance of impatience, irritability, and anger.
- B. Pressure of speech—increased volume or speed, sometimes progressing to flight of ideas, with thoughts too rapid for connections to be made.
- C. Increased motor activity—includes walking, writing, telephoning.

The above are usually present in mania or hypomania; in addition, the following may be seen:

- D. Grandiosity or overconfidence.
- E. Inappropriate language, actions, or dress.
- F. Intrusive, provocative, or manipulative behavior, frequently demanding of attention to self.

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Family Noncommunication: The Search for Kidney Donors

BY ROBERTA G. SIMMONS, PH.D., AND SUSAN D. KLEIN

Intensive study of the family communication patterns in the search for a kidney transplant donor revealed that, in a significant number of cases, communication is effectively blocked. The authors followed 83 transplant patients and their families throughout the pretransplant stage and for three weeks after the transplant. Although the noncommunication pattern appears to be maladaptive and rather stressful prior to the transplant, it seems to be beneficial for family cohesion in the period after a successful transplant.

ALTHOUGH COMMUNICATION patterns in decision making have been extensively studied in the small-group laboratory situation (1) and in large-scale organizations (2), there have been few studies of family decision making (3) or of the communication patterns that occur as "normal" families make major decisions (4-7). Since the search for a related kidney transplant donor can involve the entire extended family, this situation provides a unique opportunity to observe the communication processes that occur as a family attempts to make a major and highly stressful decision.

In many families the procedure of securing

a donor is a smooth and easy one and, according to Fellner and Marshall (8, 9), the donation itself as an altruistic act is experienced as extremely rewarding and often appears to elevate the donor's self-esteem. Yet, in a significant proportion of cases, as we have previously shown, the donor search is very difficult for both recipient and potential donor (10, 11). On the one hand, the advantage of securing a related kidney donor is very clear. At the time this study was conducted, the success rate for a kidney transplant was approximately 88 percent if a patient received a kidney from a healthy relative, but only 50 percent if he received a kidney from a person who had just died (a cadaver kidney). On the other hand, the giving of a kidney is a major sacrifice for the family member. Although the risk to his life is small (12), it is nevertheless real, as is the pain and discomfort associated with a major surgical procedure and the absence from work and consequent financial loss.

Many relatives do not feel they can make this large a sacrifice or take this risk, and their position in relation to the transplant patient can be exceedingly difficult before the transplant. This paper attempts to analyze the communication process as it involves the patient and the potential donors in his family. Since married siblings, married children, and even aunts, uncles, grandparents, and cousins are eligible as donors, the study focuses on communication in the entire extended family.

Method

This study was part of a larger investigation of the social and emotional rehabilitation of the transplant patient and his family. Fifty-nine patients who received transplants on one transplant service and 24 more who had been awaiting transplantation were followed closely throughout the donor decision-

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making process and for three weeks after the transplant. Patients, donors, spouses, and as many other family members as possible were interviewed intensively throughout the period and asked to reconstruct what was transpiring in the family. In ten of these families, there was no available relative who could be considered for donation; in all of the others some search for related donors occurred. If a willing and medically eligible relative could not be located, the patient was placed on the list to receive a cadaver kidney.¹

Findings

The overwhelming impression received from these interviews was that the communication channels are closed or considerably blocked in many of these families during the search for a kidney donor. The communication "process" can be broken down into two stages: the "request" stage and the "response" stage.

The Request Stage

The first problem for the recipient and perhaps his spouse, after they identify the possible candidates for donation, is to inform the relatives that a donor is needed. If only considerations of efficiency were involved, the most rational procedure would probably be to contact each possible donor, explain the situation, ask whether he wished to donate, and request a reply one way or the other by a given date. In this way, if no family donors were available, the patient would know quickly and be able to have his name placed on the list for a cadaver donor rapidly. The patient's waiting period would thereby be shortened, and there would be less likelihood that he would receive a blood transfusion while on dialysis that could cause him to develop antibodies against most cadaver donors.

In many families a process like this does occur. Yet a strong norm inhibits this process at the outset. The norm expressed by a high percentage of the patients is that one

should not *ask* for a kidney, one should wait for a volunteer. Recognizing the risk involved to the donor and the sacrifices he must make, the patient does not think he should be responsible for pressuring the donor into a decision. Thus patients and their spouses frequently feel under considerable constraint in communicating their need for a donor. In order to enhance the patient's chances for survival, they must somehow inform the relative that he could donate, yet they cannot be direct; they must hint.

In some cases, despite the patient's attempt to conform to this norm, the pressure on the relative appears to be quite direct. The following is from the case of patient 1, a 30-year-old woman:

Patient: I just told them I needed a donor. I wouldn't ask. If you ask you put someone on the spot.

Q: Could we go through this again, from the time you first mentioned donorship to your brother?

Patient: I called him and told him that mother had volunteered to donate but "if they won't accept mother, you'd be the only one."

In other cases, however, the request is a less direct one but just as obvious. Patient 2 was a 35-year-old woman whose brother was the donor:

Q: How was the question of a donor discussed?

Donor: Well, my sister said to us right away she'd never ask any of us to donate. She said it was too big a decision to ask anyone to make . . . to ask of anyone.

Later the donor's wife was interviewed:

Donor's wife: I was down here and Jane was fussing about it and said she would never ask anyone. So I told her she wouldn't have to ask, that Steven had already volunteered.

In still another such case, the patient, by expressing the norm and saying he would never ask for a donor, manages to convey the request. Patient 3 was a 40-year-old woman whose sister did not volunteer to donate:

Sister: My sister said she wasn't going to ask anyone in the family to donate. If they wanted to volunteer for tests this was fine. Otherwise she was going to wait for a cadaver or until someone volunteered.

¹ In all the case material presented here, names, exact ages, and other identifying characteristics of the individuals have been altered. However, the quotes are otherwise verbatim from the field notes, and the true family relationship (sibling relationship, parent-child relationship, spouse relationship) is reported.

Other patients attempt to communicate the request through joking. Patient 4 was a 20-year-old boy who is talking here about a sister, who never did volunteer to donate:

Patient: I think Brenda would do it When we're kidding around and I ask her if she wants to give me her kidney, she says no. But if I ask her serious, she'd do it I know she'd do it.

In an interview two months later with the sister:

Sister: Martin has never seriously talked to me about it. When my mom was going to donate he would say kiddingly "I don't want your kidney, I want *her* kidney."

In still other cases the request is made so indirectly that it is not clear whether the message has been received or not. In several instances the relative later claimed he did not realize he could donate or he did not realize the need was imminent, while the patient has assumed that the lack of a response is a refusal or he is left unsure whether to ask for a cadaver donor or not. Patient 5 was a 50-year-old man whose wife was interviewed; the donor was his sister.

Wife: They [the doctors] told me it was my job to ask every member but . . . I just didn't want to do it. I thought it was a very awkward situation to put a person in and as I was preparing myself to ask as a last resort—how I would do it and when would be the best time—in the midst of all this she offered.

Q: During your conversations, did Edith make any comments about the donation?

Wife: I think I did most of the talking and she did most of the listening It wasn't like we were discussing it, I was just giving her information and hoped she would understand that we wanted her to offer, that I wanted a response, but I wasn't getting it.

Q: You were hoping that she would offer so you wouldn't have to ask?

Wife: I was hoping I wouldn't have to ask but I didn't think it would work because it had been several days and I was trying to find a way to ask.

In this case, the sister claimed that the reason she had not offered earlier was that she had not realized she was a potential donor; she had thought only brothers could donate to

brothers. In other words, the indirectness of the request either prevented its being perceived clearly or allowed the sister to avoid making a decision. In another case, patient 6 communicated little information but seemed to assume, when no immediate response was forthcoming, that all siblings had refused.

Patient: They all know I'm here. They all know I'm going to have a transplant. If they were going to donate, wouldn't they have called by now?

Q: How do you know that your brothers and sisters know that a donor is needed?

Patient: Oh, they know. My mom reads about it in magazines and in the newspaper. They know more than I do probably.

Q (later): So your brothers and sisters haven't yet refused.

Patient: I could call tomorrow and get a "no."

Yet a few days later, after his wife had spoken to some of the family more directly, a sister volunteered and another sibling indicated she might consider donation.

The Response Stage

Whether or not the indirect request is obvious enough to be accurately perceived, its very indirectness allows the relative not to respond. In the words of patient 1: "If you ask, you put someone on the spot. They have to say something. But if you just leave it open, just make a statement, they can say nothing."

In fact, this lack of response is a very common pattern of behavior in these families. Frequently, the potential donor handles this difficult situation by saying nothing—he neither refuses, accepts, nor indicates he will consider the situation. He does not make excuses; he simply does not respond. This failure to respond may persist indefinitely, or in some cases for a period of time until a donor volunteers. In 17 of the 73 cases in which there were eligible relatives, some potential family donors clearly showed this pattern of nonresponse, a pattern we shall term "non-communication"; in 12 more families the evidence was less clear but pointed in this direction. In some of these situations the potential donors did agree to undergo preliminary testing or they actually had their blood tested. But while they never refused to donate, they also never proceeded to take the next step of action.

In all of these the story is similar. Patient 7 was a 19-year-old girl. Her 20-year-old brother was the donor:

Donor: She just asked if I would give her one of my kidneys. I didn't know what to say, so I didn't say anything. [Then later] . . . she asked me again and I didn't say anything. But when I found out how sick she was I said okay.

Patient 8 was a 30-year-old man; he is talking here about one married sister:

Patient: My sister in Pennsylvania has been pretty vague. Whenever I've written to ask her she doesn't answer about it. It's like I hadn't asked the question.

This noncommunication can persist for several months, as in the case of patient 9, a 56-year-old father of married children:

Patient: I saw Paul first because he was here. I told him that I was going to have a transplant and that the doctors said to line up donors.

Q: What did Paul say?

Patient: He didn't say anything at all.

Later the daughter-in-law, Paul's wife, was interviewed:

Q: Did he [the patient] ask Paul if he would donate?

Daughter-in-law: No, he would never do that. He would never pressure anyone. He just said that if any of the children wanted to, they could go in to be tested.

Q: What did Paul say?

Daughter-in-law: Nothing.

Q: Has Paul ever said anything to you about it?

Daughter-in-law: Yes, I brought it up with him. . . . I asked if he would donate. He said he couldn't donate and didn't want to talk about it. I didn't bring it up after that.

Interview with the patient, two months later:

Patient: My children had second thoughts about donating. Two of them never went in to be blood tested.

Q: Have they talked to you about it?

Patient: No. . . . They did at first. When I first told them I needed a donor, they told me they would go in to be tested. They just never did.

Interview with Paul after the transplant:

Paul: One brother didn't have the right blood type. . . . My father mentioned [to me] about who else could donate.

Q: What was it that you said about it?

Paul: I didn't say anything at the time. It was kind of brought up and then dropped and we talked about other things. We never really discussed it.

The lack of response by the relatives can be very uncomfortable for the patient and his spouse, as in the case of patient 10, a 45-year-old woman. The interview was with her husband.

Q: Have you thought any more about what you will do about the donor question?

Husband: She keeps hinting and hinting [to her brothers and sisters] but nobody says anything.

Q: How does she hint? To her brother Thomas, for instance?

Husband: Like she [says she] wouldn't want his kidney anyway, because he's so mean or something.

Q: And what would Thomas say then?

Husband: Nothing.

Q: Well, after your wife says something like this hint to one of her family members what do they say next? Do they ignore it, or change the subject, or mention some reason why they aren't too well themselves, or walk away, or what?

Husband: They just kind of leave it hanging up in the air. They just laugh, kind of—you know. They don't say anything. She doesn't ask them, so they don't have to say. She just jokes and they laugh.

Q: Have any of them said they wouldn't?

Husband: No, but none of them said they would, either. They're kind of on the fence.

Q: Have any of them said they'd think about it?

Husband: No, they don't say anything.

Of course, there are also a great many families in which the immediate response is quite direct. This is usually the case when the relative who is contacted volunteers immediately upon hearing of the need. These donors resemble those described by Fellner and Marshall (8, 9) and were also very common in the group we studied. We know that such an immediate offer to donate on the part of one or more relatives occurred in at least 38 of the families, although in some of these instances these donors were of the wrong blood type or were medically unacceptable.

Those relatives who demonstrate the pat-

tern of noncommunication are frequently those who never volunteer to donate. The one type of relative who is unlikely to exhibit this pattern of nonresponse is the patient's parent. Parents of minors, but also parents of adult children, appear to be the most willing donors, and those most likely to express their willingness immediately (9-11, 13).

Discussion

Intensive study of the family communication patterns in the search for a kidney donor has revealed that in a significant number of cases, communication is considerably blocked. Many transplant patients do not believe they should ask directly for a donor, and many potential donors who have not yet volunteered do not appear to communicate any feelings about donation to the patient. What are the consequences of this noncommunication? It cannot be assumed that closed communication channels are totally maladaptive in this situation.

It is our impression that, during the long period prior to the transplant, the stress level of the patient in many cases is increased by the noncommunication. The uncertainty may be particularly difficult, especially before he feels free to apply for a cadaver donor. As the wife of one patient said, "Well, he'd like to know one way or another, but he won't say anything. I say to him, 'I wish they'd go or get off the pot; put it in plain language.' He agrees with me, but he won't say it himself."

The period of time before the patient receives his transplant may be lengthened by this uncertainty. In addition, in order to maintain this noncommunication, some relatives find themselves unable to maintain any contact with the patient. In some cases, then, the patient finds himself, at this very difficult time, isolated from family support and he appears quite hurt by the isolation.

On the other hand, if the relative feels he cannot make the sacrifice of donation, the fact that he does not refuse outright serves some important functions. It allows him to save face and to avoid directly insulting or hurting the patient. When asked, "Why do you think you did not discuss this?" one patient's brother said, "Well, I suppose you're a little scared to face him and tell him you're turning him down"; another patient's daughter said, "I just didn't know how to tell

her I didn't feel I could donate. . . . It's kind of hard to say that to a person who's lying there and that's their only hope; so I just never brought it up."

The indirect request of the patient, by allowing the potential donors to avoid replying, also protects both the patient and the relative from a direct insult and severe embarrassment. In many extended families the ties can be very fragile and might not be able to sustain such a direct blow. Or the relationship may appear too important to endanger by an open refusal. In the words of one sister who did not communicate her doubts: "I try to put myself in her place. How would I feel if someone came and told me, 'I'm not going to help you.' I think I would resent him the rest of my life." Noncommunication also allows the *undecided* relative to avoid either committing himself or refusing prematurely.

We hypothesize that this pretransplant noncommunication has major advantages for sustaining family cohesion after a successful transplant has occurred, with the donor either a relative or a cadaver. At this time the moods of the recipient, donor, and relatives frequently change to elation, and whatever wounds have been opened by the search for a donor often are healed. The family becomes reintegrated. Family members who did not donate are sometimes able to give help to the posttransplant patient and his family. This process would appear to be much easier if the requests for a donor, the refusals, and the temporary indecisions have not been directly voiced, and if the patient's earlier anger at his relatives has not been communicated.

Furthermore, the indirectness of the earlier communication may allow the parties involved to minimize any prior unwillingness of family members to donate, thereby strengthening family cohesion. In several cases, family members who had not volunteered but who had never refused directly said after the transplant that they would have donated had the patient only waited a little longer. At this point some potential donors indicated for the first time that they had believed themselves ineligible to donate because they were of the wrong blood type, or because they believed they were not the proper sex. One patient who was upset earlier about the nondonation or indecision of some of his relatives appeared to be able to repress these prior problems in his new exhilaration and was able to tell us after

the transplant that all his eligible relatives had volunteered.

In summary, although the entire donor search can be a very smooth one for many patients, in other cases it produces significant stress for the patient and especially for those of his relatives who do not feel they can donate an organ. In a large minority of cases, the communication channels are significantly blocked during this search. One might expect the pattern of noncommunication identified here to be generalizable to a wider variety of situations in which one extended family member asks help of another. Although this block in communication may be maladaptive from the point of view of the efficiency and rapidity with which the donor problem can be settled, it may have positive functions for family cohesion, particularly once a successful transplant has been completed. And similarly, in other situations in which help is sought from within the extended family, early noncommunication may contribute to family cohesion over the long term.

It is our opinion that nothing in this study contraindicates the use of family donors. Whatever stress occurs in some families in the donor search must be balanced against the lives that would be lost if cadaver donors were used instead of family members. In addition, we cannot ignore the following sources of stress that occur more often in families where cadaver organs are used: 1) the family's grief due to the patient's death, 2) the prior stress of irreversible rejection of the transplanted kidney; and 3) the long initial waiting period for a cadaver kidney. Finally, the emotional

rewards of donating an organ to save another's life should not be overlooked (8, 9).

REFERENCES

1. Bavelas A: Communication patterns in task-oriented groups. *J Acoust Soc Amer* 22:725-730, 1950
2. Guetzkow H: Communications in organizations, in *Handbook of Organizations*. Edited by March J. Chicago, Rand McNally & Co, 1965, pp 534-573
3. Aldous J, Condon T, Hill R, et al (eds): *Family Problem Solving*. Hinsdale, Ill, Dryden Press, 1971
4. Epstein NB, Westley WA: Patterns of intra-familial communication, in *Recent Advances in Neuro-Physiological Research*, Psychiatric Research Report 11. Edited by Cameron DE, Greenblatt M. Washington, DC, American Psychiatric Association, 1959, pp 1-12
5. Hill R: Decision making and the family life cycle, in *Social Structure and the Family: Generational Relations*. Edited by Shanas E, Streib G. Englewood Cliffs, NJ, Prentice-Hall, 1965, pp 113-141
6. Morgan J: Some pilot studies of communication and consensus in the family. *Public Opinion Quarterly* 32:113-121, 1968
7. Ruesch J: *Disturbed Communication*. New York, WW Norton & Co, 1957
8. Fellner C, Marshall J: Kidney donors: the myth of informed consent. *Amer J Psychiat* 126:1245-1251, 1970
9. Fellner C, Marshall J: Twelve kidney donors. *JAMA* 206:2703-2707, 1968
10. Simmons R, Hickey K, Kjellstrand C, et al: Family tension in the search for a kidney donor. *JAMA* 215:909-912, 1971
11. Simmons R, Hickey K, Kjellstrand C, et al: Donors and non-donors: the role of the family and the physician in kidney transplantation. *Seminars in Psychiatry* 3:102-115, 1971
12. Hamburger J, Crosnier J: Moral and ethical problems in transplantation, in *Human Transplantation*. Edited by Rapaport F, Dausset J. New York, Grune & Stratton, 1968, pp 37-43
13. Eisendrath R, Guttman R, Murray J: Psychological considerations in the selection of kidney transplant donors. *Surg Gynec Obstet* 129:243-248, 1969

Comparing MMPI Statements and Mental Status Items

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In a direct comparison of Minnesota Multiphasic Personality Inventory (MMPI) responses and mental status interview content, MMPI statements were judged to overlap only 40 percent of standard mental status items, with a range of agreement from three to 87 percent when the same 100 psychiatric patients were evaluated with both procedures. Differences in content emphasis between the two procedures are discussed. Although the MMPI and the standard mental status examination complement each other, the authors discourage attempts to substitute one for the other.

AUTOMATION OF THE Minnesota Multiphasic Personality Inventory (MMPI) has sharply increased its utilization in psychiatry (1). Very little effort is required to administer the test. Most patients readily accept the testing procedure. Responses are machine scored and a report is machine generated in an inexpensive, expeditious manner. As a direct result of its increased use by psychiatrists, interest has developed in the relationship of the

MMPI to the psychiatric interview. A close relationship might be expected since the MMPI statements developed by Hathaway and McKinley were taken "... from several psychiatric examination forms, from various textbooks in psychiatry, from certain of the directions for case taking in medicine and neurology and from the earlier published scales of personal and social attitudes" (2).

A search of the MMPI literature failed to yield a single study that compared patients' MMPI responses directly with the content of their psychiatric interviews. Wiggins, commenting upon this, stated: "The concept of item *content* has enjoyed neither precise specification nor active empirical exploration. . . ." He suggested that this may, in part, be related to "... the superstition that knowledge of the content of an empirical scale may somehow vitiate the mysterious mediating process that links scale score to empirical criteria" (3).

The study reported in this paper examines the relationship between MMPI statements and mental status items. Two questions were posed: What MMPI statements overlap standard mental status items? When overlap did occur, did patients respond to the MMPI statements in a manner similar to the way they responded on the mental status examination?

Method

Patient Selection

One hundred patients were selected for this study from the enlisted men's psychiatric admission ward at Walter Reed General Hospital. The median age for this sample was 20 years, with a range of 16 to 50 years. Seventy percent of the subjects were single; 41 percent had not completed a high school education;

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and 78 percent were Caucasian. Most of these patients had been in the military service for a short period of time; the median length of service was one year. The final diagnoses for this patient sample were: schizophrenia, 47 percent; personality disorder, 23 percent; transient situational disturbance, 14 percent; neurosis, six percent; drug dependence or alcoholism, six percent; and miscellaneous diagnoses, four percent. Only 13 patients had a prior history of psychiatric hospitalization.

Examination Procedures

Each patient took the card-sort form of the MMPI shortly after admission (median = two days; range = 0–15 days). Shortly after administration of the MMPI (median = one day; range = 0–14 days), the patients were seen by two psychiatrists. One psychiatrist conducted the diagnostically oriented, open-ended interview lasting from 45 to 90 minutes while the other psychiatrist remained as a passive observer. Immediately following the interview each psychiatrist recorded his observations on a standard mental status form independent of the MMPI results and of his colleague's rating. The task of interviewing was rotated among the five participating psychiatrists.

The mental status form consisted of 120 operationally defined items distributed among 14 categories.¹ Appendix 1 illustrates the format by presenting the Mood category. The remaining categories are: Attitude (11 items), Dress and Habits (five), Motor Behavior (nine), Speech (five), Facial Expression (seven), Affect (five), Thought Processes (11), Thought Content (15), Perceptual Disorders (five), Conversion and Somatization (three), Physical Symptoms (16), Intellectual Functioning (18), and Insight (three). Using this form, interrater reliability over all 120 items was 87 percent. The median positive agreement (i.e., both psychiatrists agreed that an item was present) was 50 percent; 40 items attained at least 60-percent agreement.

The psychiatrists agreed 74 percent of the time with respect to the primary diagnosis and 96 percent of the time when alternative diagnoses were included. Table 1 presents these results, which compare favorably with other reports in the literature (4, 5).

¹ A copy of the Walter Reed Mental Status Examination is available from the authors upon request.

Relating MMPI Statements to Mental Status Items

When the data collection was completed we systematically reviewed each of the 550 MMPI statements and, based upon the manifest content, related them to the mental status items. Some MMPI statements related to the corresponding mental status items in a total fashion, i.e., both the true and false responses were judged to relate. Other MMPI statements related in a partial fashion, i.e., either the true or the false response was judged to relate.

Results

Overlapping of MMPI Statements and Mental Status Items

Only 174 of the 550 MMPI statements (32 percent) were judged to relate to at least one item on the mental status examination. Only 48 of the 120 mental status items (40 percent) overlapped at least one MMPI statement. Twenty-two of the 174 MMPI statements were referable to more than one mental status item. For example, a "true" response to the MMPI statement "I believe I am a condemned person" was judged to be rationally related to a positive response on the mental status items Delusions and Hopelessness. Table 2 displays the degree of overlap in each mental status category. Three categories—Speech, Facial Expression, and Insight—contained no items that were overlapped by MMPI statements. The categories Mood, Conversion and Somatization, and Physical Symptoms had more than a 50-percent overlap with the MMPI. All 15 mental status items in the category Thought Content were overlapped by at least one MMPI statement.

Similarity of Patient Responses

Having identified the MMPI statements and mental status items that rationally overlap each other, the next question was, Do patients give similar responses in the MMPI statements and in the mental status examination? In the analysis of this similarity, two factors were found to be relevant. The first factor was whether a total or partial comparison existed between the MMPI statement and the mental status item. If a partial comparison was found, the second factor was the frequency with which the mental status

TABLE 1
Primary Diagnosis Agreement Between Interviewing and Observing Psychiatrists
(N = 100 Patients)

INTERVIEWER	OBSERVER					
	SCHIZO- PHRENIA	PERSONALITY DISORDER	TRANSIENT SITUATIONAL DISTURBANCE	NEUROSIS	DRUG DEPENDENCE OR ALCOHOLISM	OTHER*
Schizophrenia	44**	3	—	—	—	3
Personality disorder	3	9**	4	1	1	1
Transient situational disturbance	1	2	7**	1	—	—
Neurosis	1	—	—	2**	—	—
Drug dependence or alcoholism	—	2	—	—	8**	—
Other*	2	1	—	—	—	4**

*Includes the following diagnoses: enuresis, involuntal melancholia, psychosis with drug intoxication, nonpsychotic organic brain syndrome with drug intoxication, manic-depressive illness, paranoid state, mental retardation, psychophysiologic disorder.

**Indicates agreement: total agreement was reached for 74 patients.

item was reported to occur in the patient sample. For the statements and items related in a total fashion, the agreement was between 50 and 60 percent. The percentage of agreement for MMPI statements and mental status items related in a partial fashion, however, varied with the frequency of occurrence of the mental status item. Mental status items that were infrequently reported had a low percentage of agreement with their corresponding MMPI statements. Conversely, frequently reported mental status items produced the highest percentage of agreement with the overlapped MMPI statements.

As noted earlier, no mental status items in the categories Speech, Facial Expression, and Insight were overlapped by MMPI statements. In the category Attitude, only the item Suspicious, which occurred in 36 patients,

was overlapped even in a partial manner by the MMPI statement "It is safer to trust nobody." The agreement between the patients' MMPI responses and the mental status rating on these items was only 18 percent. In the category Affect, the mental status item Fearful occurred in only 20 patients. The overlapping MMPI statement was related in a partial manner, and the agreement was 24 percent.

In a similar manner, the mental status item Flight of ideas within the category Thought Processes occurred in 14 patients and was related in a partial manner to the overlapping MMPI statement. The degree of agreement (14 percent) was also low. Within the category Dress and Habits two MMPI statements related in a total fashion to the specific mental status item Use of alcohol. The amount of agreement between the two MMPI statements and this item was 61 and 50 percent respectively. Concerning another personal habit, Illegal use of drugs, the agreement reached 74 percent with the one MMPI statement "Except by a doctor's orders, I never take drugs or sleeping powders."

In the category Motor Behavior the specific items Increased motor behavior and Unusual motor behavior agreed with their overlapping MMPI statements—61 and 96 percent respectively. Also within the category of Motor Behavior the specific mental status item Compulsive acts was overlapped by three MMPI statements. Compulsive behavior was not observed among the subjects; however, 20 to 40 percent of the patients endorsed the MMPI statements that were judged to relate to the item Compulsive acts. Thus these three MMPI statements tend to

TABLE 2
Percentage of Mental Status Items Overlapped by
MMPI Statements

CATEGORY	NUMBER OF ITEMS	PERCENTAGE OF ITEMS OVERLAPPED
Attitude	11	9
Dress and habits	5	40
Motor behavior	9	33
Speech	5	0
Facial expression	7	0
Affect	5	20
Mood	7	86
Thought processes	11	9
Thought content	15	100
Perceptual disorders	5	20
Conversion and somatization	3	67
Physical symptoms	16	69
Intellectual functioning	18	28
Insight	3	0
Total	120	40

TABLE 3
Percentage of Agreement Between MMPI Statements
and Mental Status Items

CATEGORY	NUMBER OF STATEMENTS	PERCENTAGE OF AGREEMENT	
		MEDIAN	RANGE
Mood	24	49	3-66
Thought content	76	42	12-86
Perceptual disorders	8	54	44-63
Conversion and somatization	30	18	4-72
Physical symptoms	17	61	21-87
Intellectual functioning	18	62	16-71

point out potential symptoms not uncovered in the mental status examination.

Percentage of agreement for the remaining six mental status categories is summarized in table 3. All categories except Perceptual Disorders had a wide range of agreement. The categories of Physical Symptoms and Intellectual Functioning had the highest median percentage of agreement with the overlapping MMPI statements. All of the mental status items within the category Conversion and Somatization had a low frequency of occurrence and also were related in a partial fashion to the overlapping MMPI statements. Thus the resulting agreement between the MMPI statements and the mental status items in this category was poor.

Discussion

In this study MMPI statements were judged to overlap only 40 percent of the mental status items, and agreement between the rationally equivalent pairs of items ranged from three to 87 percent when the same 100 psychiatric patients were evaluated with both procedures. While such findings may be surprising, it must be remembered that despite a number of similarities in content and purpose, the two procedures are quite different.

The MMPI consists of a fixed number of true-false questions that the patient relates to himself without outside interpretation or clarification. These statements concentrate on the patient's attitudes, beliefs, feelings, thoughts, and preferences. Many items are vague and without temporal reference. Each item response is subject to the patient's understanding, motivation, and highly subjective interpretation. On the other hand, the mental status examination is an open-ended, highly interpersonal interview situation in which any unusual responses by the patient can be im-

mediately explored and from which the psychiatrist makes judgments about the patient. These judgments may or may not accord with what the patient might say about himself, and they are specifically directed toward an evaluation of the patient's current status.

Differences in content emphasis between the two procedures are illustrated by the fact that no item overlap occurred in the mental status categories of Speech, Facial Expression, and Insight. Some overlap occurred in the areas of Attitude, Dress and Habits, Motor Behavior, Affect, Thought Processes, Perceptual Disorders, and Intellectual Functioning. The areas of greatest overlap were Mood, Thought Content, Conversion and Somatization, and Physical Symptoms.

One possible explanation for the low degree of overlap is that the MMPI statements might have been misclassified. The judgments were quite arbitrary and were made by clinicians. As Hathaway and McKinley pointed out in their original grouping of MMPI statements into 26 categories, there is room for error (6). Another possible explanation is that the mental status examination did not contain enough items or the proper items. Perhaps if this same study were repeated using a longer mental status form (7, 8), more overlap would be found. The mental status form used in this study was chosen because it suited the needs of clinicians at Walter Reed General Hospital, where there is a rapidly changing patient population and the emphasis is on differential diagnosis.

It may also be that the statistical approach used was too limited. A "shotgun" correlation of all 120 mental status items with all 550 MMPI statements might have produced different results. This approach was discarded because of the high probability of finding some of the more than 12,000 comparisons to be statistically significant due to chance alone. The content of the MMPI statements might not clinically relate to the mental status items and, again, an arbitrary clinical judgment would be involved.

At Walter Reed General Hospital the MMPI is used as an adjunct to diagnosis. Clinicians have developed an appreciation for relating the profiles to their individual patients. The MMPI may uncover significant symptoms or complaints that are not recognized in the initial interview. By endorsing particular MMPI statements, patients can ac-

knowledge certain problem areas that they cannot discuss in their interpersonal interviews. The psychiatrist's exploration with the patient of any bizarre or unusual responses to the MMPI statements can be most enlightening and sometimes facilitates diagnosis.

This study should in no way be construed to detract from the pioneering contributions of Finney, Fowler, Gilbertstadt, Glueck and Reznikoff, and Swenson and others, who have produced automated MMPI examinations (9-13). It is important to note that a comparison of the content similarity between the MMPI statements and the mental status items, or of the degree to which patients and psychiatrists agree in ascribing such items to patients, may have little to do with current actuarial use of the MMPI in patient evaluation. While it may be clinically helpful to attend to specific MMPI content, as in the clinical use of critical items that have been answered in a deviant manner, few current actuarial uses of the MMPI pay attention to the content per se. The actuarial uses relate simply and empirically specific MMPI performance characteristics to other behavioral events or to other independent judgments concerning the patients.

The results of this study suggest, however, that clinicians must take cognizance of the differences between the MMPI examination and the clinical interview. Marked differences exist in the procedures, and while they tend to complement each other, the attempt to substitute one for the other should be discouraged.

REFERENCES

1. Fowler RD Jr: The current status of computer interpretation of psychological tests. *Amer J Psychiat* 125 (Jan suppl):21-27, 1969
2. Hathaway SR, McKinley JC: Construction of the schedule, in *Basic Readings on the MMPI in Psychology and Medicine*. Edited by Welsh GS, Dahlstrom WG. Minneapolis, University of Minnesota Press, 1956, pp 60-63
3. Wiggins JS: Content dimensions in the MMPI, in *MMPI: Research Developments and Clinical Applications*. Edited by Butcher JN. New York, McGraw-Hill Book Co, 1969, pp 127-180
4. Beck AT, Ward CH, Mendelson M, et al: Reliability of psychiatric diagnoses: 2. A study of consistency of clinical judgments and ratings. *Amer J Psychiat* 119:351-357, 1962
5. Kendell RE, Cooper JE, Gourlay AJ, et al: Diagnostic criteria of American and British psychiatrists. *Arch Gen Psychiat* 25:123-130, 1971
6. Hathaway SR, McKinley JC: The basic scales, in *An MMPI Handbook*. Edited by Dahlstrom WG, Welsh GS. Minneapolis, University of Minnesota Press, 1965, pp 43-85
7. Spitzer RL, Fleiss J, Kernohan W, et al: Mental status schedule. *Arch Gen Psychiat* 12:448-455, 1965
8. Donnelly J, Rosenberg M, Fleeson WP: The evolution of the mental status—past and future. *Amer J Psychiat* 126:997-1002, 1970
9. Finney JC: Purposes and usefulness of the Kentucky program for the automatic interpretation of the MMPI. Read at the 73rd annual meeting of the American Psychological Association, Chicago, Ill, September 2-7, 1965
10. Fowler RD: *The MMPI Notebook: A Guide to the Clinical Use of the Automated MMPI*. Nutley, NJ, Roche Psychiatric Service Institute, 1966
11. Gilbertstadt H: *Comprehensive MMPI Codebook for Males*. Washington, DC, US Government Printing Office, 1970
12. Glueck BC Jr, Reznikoff M: Comparison of computer-derived personality profile and projective psychological test findings. *Amer J Psychiat* 121:1156-1161, 1965
13. Swenson WM, Rome HP, Pearson JS, et al: A totally automated psychological test: experience in a medical center. *JAMA* 191:925-927, 1965

APPENDIX 1

Sample Category from Walter Reed Mental Status Examination*

MOOD (Subjective patient report of his feeling tone over time)

43. Apathy—lack of feeling tone.
44. Mood elevated—patient's subjective elevation of spirits.
45. Mood depressed—patient's subjective lowering of spirits.
46. Mood labile—inordinate variability of sustained subjective feelings.
47. Cyclothymic—periodic excessive variation of subjective feelings.
48. Uneasiness—an uncomfortable, painful, foreboding subjective feeling (if cause is known, it would be defined as fear and if the cause is unknown, defined as anxiety).
49. Diurnal variation—regular shift in subjective feeling in a 24-hour period.

* Each item is defined for the examiner. Room is left on the scoring form for verbatim recording of narrative information, and each item is expected to be scored on a scale of severity from 0 to 4 (0 = none, 1 = minimal, 2 = moderate, 3 = severe, 4 = extreme).

Change of Command in Combat: A Locus of Stress

BY DOUGLAS R. BEY, JR., M.D.

In the military a change of command is particularly stressful for the members of the unit involved. A comparison of units, some of which showed few increases in the indices of organizational stress and some of which showed great increases, revealed a relationship between the administrative style of the departing commander and the amount of stress experienced by the unit. The author describes methods used in the Army's First Infantry Division to help prevent excessive stress during the replacement period.

PSYCHIATRIC PROGRAMS in the military, as well as in the civilian community, have increasingly emphasized prevention. The advances in our understanding of family, group, and organizational dynamics have enabled psychiatrists in Viet Nam to study and to develop techniques for primary prevention within the well-organized structure of the military community. High-risk individuals and predictable stress periods within combat units have been identified and reported (1-10). Some techniques have been described to protect these soldiers and their units (2, 3, 11). This paper will describe one period of increased stress in the life of combat units—a change of command. I will report the stress experienced by field units during a change of command and explore the dynamics of this period and our efforts to reduce this stress in the Army's First Infantry Division.

Development of Preventive Measures

In World War I Salmon demonstrated that fewer losses for psychiatric reasons occurred

when men were treated near the front soon after they developed symptoms and when the treating physicians anticipated the return of these men to duty (12). Hausman and Rioch later coined the terms "immediacy, proximity, and expectancy" to describe these principles (13). These lessons were overlooked in World War II until evacuations of men for psychiatric reasons became a serious threat to the war effort, at one point outnumbering enlistments and equaling a division per month for the European Theater (14). William Menninger (15) noted the important connection between a psychiatric diagnosis and the associated prognosis and that a diagnosis of "combat exhaustion" was used for soldiers who developed psychiatric symptoms in the combat area. (Menninger noted that in war psychiatrists treated normal reactions to an abnormal situation.) Menninger further supported the principles of Salmon by assigning psychiatrists to infantry divisions starting in March 1944. He indicated that "the most important functions of military psychiatry are primarily preventive..." (15, p. 337). Division psychiatrists were from the outset given staff positions and instructed to serve as command consultants as well as to provide direct services within their units (15).

During World War II the important role of paramedical personnel in providing psychiatric service was demonstrated (16). Spiegel described the tremendous supportive function of the combat group for its members and noted that men seemed to continue to fight not out of hatred for the enemy but rather out of love for their fellow soldiers (17). Appel and Beebe studied the relationship between the duration of combat stress and the onset of psychiatric symptoms. Glass reported their unpublished data, which noted that infantry troops after 100 days of intermittent exposure to battle began to show symptoms of "combat exhaustion" (18).

The Mental Hygiene Consultation Service

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in U.S. training facilities was initiated in 1942, with emphasis on unit consultation and the development of preventive programs (19). In 1947 the Army started its formal training program for social work/psychology technicians (20).

Caldwell and Glass initiated division psychiatric programs immediately with the onset of the Korean campaign. Studies of the effects of brainwashing further substantiated the importance of group support in enabling the individual soldier to tolerate stress (21). Epidemiological studies by Glass demonstrated that the development of psychiatric symptoms was more closely related to the emotional climate of the unit and to factors of secondary gain than to the time spent in combat (18). Glass also observed that older, less experienced, and less educated soldiers were at high risk for the development of psychiatric symptoms (18, 22).

Parrish further developed programs of preventive psychiatry in the United States and in Viet Nam. He observed that the individual soldier's symptoms were often a reflection of increased stress within his unit rather than a manifestation of individual pathology (23). In 1963 Gen. Westmoreland urged commanders to use military psychiatrists as personnel management consultants (24). With this background and with the inclusion of family, group, and organizational dynamics in the curricula of many psychiatric training programs, psychiatrists in Viet Nam were able to describe high-risk individuals and periods of increased stress within combat units and to develop some techniques for the primary prevention of psychiatric casualties within their divisions (2, 3, 9-11, 24, 25).

Monitoring Unit Stress

In the First Division, as previously described (11), we monitored each month for each battalion in the division the number of sick-call referrals (non-effective rate), mental hygiene referrals, complaints to the inspector general, administrative discharges, Article 15s, court martials, accident rates, venereal disease rates, and the incidence of vivax malaria.¹ We observed that several company-

sized units showed a marked increase in organizational symptoms following the replacement of their company commanders. We also observed that other units showed some elevation in these indices of organizational stress, while still others showed slight or few signs of stress.

Psychiatry's interest in the identification of stress periods and primary prevention is fairly recent. However, these periods have been known intuitively for centuries, and society has provided ways of reducing stress for the individual. For example, baptisms, communion, weddings, and funerals are ceremonies provided by the church to help reduce the stress of birth, adolescence, marriage, and death. Organizations and institutions as well have intuitively developed ceremonies and rituals to cope with stress. The military is no exception, and the change of command ceremony represents such an attempt to ritualize and to reduce the organizational stress during this significant replacement period. The unit's colors are passed to the incoming commander and a party is held for the old commander in which the unit has its "last supper" together and presents the outgoing commander with farewell gifts.

In consulting with units, some of which showed little and some of which showed great stress during this period, some differences in command were observed. We noted that the interaction between the unit experiencing a change in command and the departing commander appeared to be greatly affected by the administrative style of the commander prior to his leaving. Units whose commanding officers became informal and lax in their discipline prior to the change of command and units that tended to idealize their commander showed more evidence of stress during and following the change of leadership period. This was very obvious in some extreme examples. One excellent documentary concerning the stress experienced by the combat unit during this period was contained in a Special Report, "The World of Charlie Company" televised by the Columbia Broadcasting System. The unit idealized the departing captain and regarded his replacement with distrust, suspicion, and hostility. The unit initially refused to follow the new commander's orders, but after a period of decreased effectiveness and increased stress, the infantry company accepted him.

¹ The malaria rate was used as a "command indicator" because the incidence of vivax malaria directly reflected whether or not the men had taken their chloroquin primaquine tablets, a function of discipline and morale.

The Dynamics of Change of Command

As noted in a previous paper, the combat company is a vitally interdependent group whose safety depends on group integrity and on its leadership. As we know from studies of individual and group dynamics, change in itself produces uncertainty and evokes a basic fear of loss. The unit commander is, by virtue of his position, responsible for the lives of his company's soldiers. Not only is he responsible for their clothing, food, shelter, punishment, privileges, and discipline, but he must also make day-to-day decisions that may result in their survival or death on the battlefield. Thus, the unit views the departure of its commander as a significant loss of an important figure. It represents the loss of identity of the unit itself, as developed under the commander's leadership. Strong negative as well as positive feelings toward the departing leader are evoked. This situation is akin to the termination of any close, significant relationship.

In the units where the soldiers showed considerable stress and difficulty in assimilating the new leader during the replacement period, the departing commander seemed to make an unconscious effort to keep down their angry feelings. More specifically, the leader tended to loosen his controls, to give additional privileges, awards, and gifts to his unit. The unit encouraged this tendency by praising him, joking about his extension of privileges, and expressing apprehension about his successor. The leaders of these companies provided little opportunity for their units to express their angry feelings of abandonment. For example, hints by the unit members that they would forget him following his departure evoked further privileges from the commander. At the same time these leaders left the less agreeable disciplinary duties to their successors. Frequently they tended to over-brief their replacements and in some instances they supported the units' apprehension of their successors. An example of this process from the First Infantry Division will illustrate these dynamics.

Case Report

Capt. X was preparing to end his tour. He had done a fine job commanding his combat unit, which was highly regarded for its efficiency. As his

date of departure approached, he began to be cynical and critical of his own commanding officer, Lt. Col. Y, and of the "system" in general. He became informal in his relationship with the enlisted men of his company and began frequenting their quarters and inviting them to his hooch for bull sessions. The content of these sessions often centered around the ignorance and nit-picking of Lt. Col. Y.

Capt. X's unit felt that Capt. X was a rare officer who understood and took the side of his unit. On the other hand Lt. Col. Y was seen as being the source of all of the "harassment" in the unit. The unit was apprehensive regarding Lt. Col. Y's choice of replacement for Capt. X. They feared he would select someone like himself who would be punitive toward them; rumors circulated that Lt. Col. Y was sending up "a tough guy to shape up the unit."

The night the new commander, Capt. Z, took command a claymore mine was triggered in his hooch and a note was posted warning him "not to try any chicken shit with this unit." For a turbulent period of several weeks any order from Capt. Z was regarded as "harassment" and was resisted by the unit. The parameters of organizational stress described previously showed an abrupt increase.

The unit's irrational fear and negative feelings toward the new leader gradually decreased in intensity to the extent that after a month the company men began to observe some of his many positive qualities. As this occurred Lt. Col. Y again became the focus of angry comment. Capt. Z was seen as not being so bad but as having had the misfortune to have Lt. Col. Y as a commander. In two months the unit returned to its previous level of efficiency, and the indices of organizational stress returned to their pre-replacement levels. During the replacement period one suicide occurred in the unit, and several men with characterological problems were referred to division psychiatric facilities for evaluation and treatment.

In this extreme example one can see how Capt. X's relationship with his unit prior to his departure appeared to be directly related to the difficulties the company experienced when he was gone. He unconsciously avoided the negative feelings that his leaving engendered in his company. By loosening his controls and by becoming a "buddy" to his men Capt. X made it difficult for them to express any feelings other than positive ones for him. Further, Capt. X provided the unit a scapegoat for their angry feelings, Lt. Col. Y. When Capt. Z replaced the idealized Capt. X, he was the immediate recipient of all of the angry feelings that the unit could not express toward Capt. X.

In other units we visited during and follow-

ing changes of command there was little stress. These commanders had learned or knew intuitively the value of tightening their controls and providing ways to allow their men to express their angry feelings prior to their departure. In discussing our observations regarding change of command with these leaders, they indicated that our explanations made sense to them but that their administrative style had not been guided by a dynamic understanding of the change of command period. Most said they were not aware of doing anything different from usual prior to leaving. Several said that they had made a special point of taking care of any unpleasant duties (usually disciplinary) before leaving so as not to leave their "dirty wash" for the incoming commander.

Primary Prevention

Informally and through our consultations with our division's units we made a point of discussing with commanding officers the impact of their leaving on their units. We discussed the dynamics of the replacement period and pointed out some examples of how other commanders dealt with it within their units. We illustrated the effect of administrative styles on the unit in terms of organizational stress and the company's effectiveness. In this informal way we learned from the experienced commanders. We served as disseminators of information by sharing the experiences of the commanders and in addition offered our experiences with regard to the psychodynamics inherent in terminating and changing therapists in individual and group psychotherapy.

In addition, we shared our findings with the battalion surgeons as part of their orientation when they arrived in the division. We also published our observations in the division's command health report and in the USARV Medical Bulletin. We do not have hard data to support our contention that our efforts served to prevent psychiatric casualties within our division's units, but our observations of the indices of organizational stress appeared to us to support our contention that these efforts were worthwhile.

Finally, we were again made aware of the principle that in the military an increase in psychiatric referrals was more often a reflection of organizational stress in a unit than an

indication of an epidemic of mental illness (12).

REFERENCES

1. Bey DR: Division psychiatry in Viet Nam. *Amer J Psychiat* 127:146-150, 1970
2. Bey DR: Group dynamics and the "F.N.G." in Vietnam—a potential focus of stress. *Int J Group Psychother* (in press)
3. Bey DR, Zecchinelli VA: Marijuana as a coping device in Vietnam. *Milit Med* 136:448-450, 1971
4. Talbott JA: The Saigon warriors during TET. *USARV Medical Bulletin* pp 60-61, Mar-Apr 1968
5. Huffman RE: Which soldiers break down. *Bull Menninger Clin* 34:343-351, 1970
6. Morris LE: "Over the hump" in Vietnam. *Bull Menninger Clin* 34:352-362, 1970
7. Crowe RR, Colbach EM: A psychiatric experience with project 100,000. *Milit Med* 136:271-273, 1971
8. Herral JM: Birth order as a patient variable in combat zone psychiatry. *USARV Medical Bulletin* pp 29-33, Nov-Dec 1969
9. Baker W: Division Psychiatry: 9th Infantry Division. *USARV Medical Bulletin* pp 5-9, Nov-Dec 1967
10. Pettera RL, Johnson BM, Zimmer R: Psychiatric management of combat reactions with emphasis on reaction unique to Vietnam. *Milit Med* 134:673-678, 1969
11. Bey DR, Smith WE: Organizational consultation in a combat unit. *Amer J Psychiat* 128:401-406, 1971
12. Salmon TW: The war neuroses and their lessons. *New York J Med* 109:993-994, 1919
13. Hausman WA, Rioch DM: Military psychiatry: a prototype of social and preventive psychiatry in the United States. *Arch Gen Psychiat* 16:727-739, 1967
14. Farrell MJ, Berlien IC: Professional personnel, in *Neuropsychiatry in WW II*. Edited by Anderson RS. Washington, DC, Office of the Surgeon General, Department of the Army, 1966, pp 49-50
15. Menninger WE: *Psychiatry in a Troubled World*. New York, Macmillan Co, 1948, p 337
16. Rodeman CR, Seidenfeld MA, Rockmore MJ: The technicians, in *Neuropsychiatry in WW II*. Edited by Anderson RS. Washington, DC, Office of the Surgeon General, Department of the Army, 1966, pp 701-717
17. Spiegel HX: Psychiatric observations in the Tunisian campaign. *Amer J Orthopsychiat* 14:381-385, 1944
18. Glass AJ: Observations upon the epidemiology of mental illness in troops during warfare, in *Symposium of Preventive and Social Psychiatry*, Walter Reed Army Institute of Research, WRAMC, Washington, DC, Apr 15-17, 1957. Washington, DC, US Government Printing Office, 1957, pp 185-198
19. Allerton WS, Peterson DB: Preventive psychiatry—the Army's Mental Hygiene Consultation Service (MHCS) program with statistical evaluation. *Amer J Psychiat* 123:1585-1586, 1967
20. Nolan KJ, Cooke ET: The training and utilization of the mental health paraprofessional within the military: the social work/psychology specialist. *Amer J Psychiat* 127:74-79, 1970
21. Group for the Advancement of Psychiatry: *Methods of Forceful Indoctrination: Observations and Interviews*, symposium no 4. New York, GAP, 1957

22. Glass AJ: Psychotherapy in the combat zone. *Amer J Psychiat* 110:725-730, 1954
23. Parrish MD: The problem of being from Iowa. *Medical Bulletin US Army Europe* 22:467-468, 1965
24. Westmoreland WC: Mental health—an aspect of command. *Milit Med* 128:209-214, 1963
25. Bey DR, Smith WE: Mental health technicians in Vietnam. *Bull Menninger Clin* 34:363-371, 1970

DISCUSSION

PERRY B. BACH, M.D. (San Diego, Calif.)—Dr. Bey's paper presents a useful review of the literature on the preventive aspects of military psychiatry and focuses our attention on their practical application in a specific, potentially stressful situation. The review of the literature concisely describes the development of primary preventive psychiatry within the Army, leaving the reader with a feeling of orderly progression and the acceptance of preventive psychiatry throughout the military. Regrettably, this is not so.

The Army is unique among the military services in its use of primary preventive psychiatry; the Navy and Air Force only infrequently use psychiatrists on active duty as consultants, either at command levels or in operational units. In fact, psychiatrists are most frequently used in secondary prevention or in "psychiatric military duty" (1, 2). This is a reflection of both structural and philosophical differences among the services, so it is only with extra effort and expertise that Navy and Air Force psychiatrists (especially the noncareer officers) are able to intercede meaningfully at command levels to effect primary prevention programs and policies.

Other problems and limitations of the Army's preventive psychiatry approach have been discussed by Friedman (3).

The idea of monitoring stress within units and of applying this by providing guidance to those units which need it most is a significant contribution to military psychiatry. A basic assumption underlying this approach is that the military command is receptive to psychiatric consultation and welcomes any contribution. In reality, this reception varies greatly with the military commander, the branch of service, the psychiatrist, and the circumstances in which they come together.

The discussion of the dynamics of changing command and of the potential for stress illustrated both the difficulties and the positive aspects that can occur. The difficulties suggest that insufficient thought or planning is given to the most effective manner of changing command. The Navy finds it useful to have the current and prospective commanding officers overlap with a "turnover" period. Many squadrons have a man serve as the executive

officer one year, becoming the commanding officer in the same unit the following year. The Marine Corps, however, frequently assigns officers to units without any apparent forethought regarding change of command. An officer may arrive at his duty station only to find that he outranks the current commander, that he is now in charge, and that no preparation has been made for either the old or the new commanding officer, let alone the unit and its men.

Dr. Bey noted that society has traditionally provided rituals for stressful periods. One example specifically related to change of command can be found in the Bible, when Moses turned over his command to Joshua (4). The announcement of the change, the appointment of the successor, reassurances of continued guidance from Above, a review of the past and the prospects for the future (including both the positive and negative aspects of each), and permission to grieve associated with an obligation to support the new leader and to continue the mission are all spelled out in detail and could serve as a model.

We must therefore question why changes in command have not been adequately ritualized or become consistent and effective. The answer may lie in the uniqueness of each military service, the circumstances surrounding each change, and the needs of the specific officers. In the Navy aboard ships, it is especially important that leadership be continuous and flow evenly from one commander to the next. In the Marines, it may be more important for the men to relate most strongly to their unit as a whole rather than to specific individuals who temporarily act as their leaders. The consulting psychiatrist must therefore consider the needs of the particular operation or mission before practicing preventive psychiatry in a civilian sense, as well as focusing on the feelings and needs of the individual commanders as they arrive and depart.

Dr. Bey's paper is informative and useful. My only major regret is that it is directed to a group of psychiatrists rather than to military officers. The information it contains will only be useful when those who have the most to gain from it, namely the military services, are receptive and willing to provide the necessary structure to transmit it in an effective manner.

REFERENCES

1. Barr NI, Zunin LM: Clarification of the psychiatrist's dilemma while in military service. *Amer J Orthopsychiat* 41:672-674, 1971
2. Bach PB: Psychiatric military practice. *USAF Medical Service Digest* 22(11):1-4, 1971
3. Friedman HJ: Military psychiatry: limitations of the current preventive approach. *Arch Gen Psychiat* 26:118-123, 1972
4. Deuteronomy 31-34; Joshua 1

A Comparison of Amok and Other Homicide in Laos

BY JOSEPH WESTERMEYER, M.D., M.P.H., PH.D.

Past studies of amok have focused on the psychopathology of incarcerated survivors; this study, which compares amok with other forms of homicide in Laos, emphasizes social factors as well. Results indicate that objective criteria can be developed for amok and that certain social variables concerning the homicidal person also distinguish between amok and other homicide. However, psychological characteristics prior to amok did not vary significantly for the two groups.

AMOK, a Malay word meaning "to engage furiously in battle," refers to those instances in which a person suddenly and unexpectedly begins an indiscriminate assault on those about him (1). Bladed weapons have traditionally been employed for amok in southeast Asia. Recently, however, the literature records the use of rifles by Indonesian soldiers (2) and the use of Thompson submachine guns by Filipino soldiers (3).

Studies on the psychiatric aspects of amok have focused on the person who has run amok (2-16). With the exception of Burton-Bradley's work (17), the social context of the amok event has received little attention. In the present study, the social context as well as the individual is emphasized. Comparison with other forms of homicide demonstrates the elements characteristic of amok homicide in Laos.

Method

Informants from prior fieldwork in Laos were asked to locate instances of amok and other homicide. Interviews were then held with village and district leaders (*naiban* and *tasseng*), Buddhist monks in the area, and medical personnel. Relatives, friends, and neighbors of the homicidal persons and their victims were also contacted. In five instances, both the slayer and his prison guards were interviewed. The number of informants per homicidal event varied from three to eight persons. Throughout the data collection, communication occurred almost exclusively in the Lao language without translators. The cases originated mostly from the Vientiane district, an area with a population of about 200,000.

Results

A total of 32 homicidal cases were obtained. Twenty of these were amok events, and 12 were non-amok homicides. Since the term amok contains strongly subjective elements ("suddenly and unexpectedly begins an indiscriminate assault"), we shall look first at the two types of events to see whether they do indeed differ from each other by objective criteria. Then we shall examine the homicidal persons.

The Homicidal Event

Weapon. During recent years in Laos, amok persons have generally employed the grenade, a weapon that randomly kills and maims (see table 1). Of 20 amok cases, only two persons employed the traditional bladed weapons. In contrast, non-amok homicides generally occurred by gunshot, a more selective method. Choice of weapon discriminated between the two types of homicide at a highly significant level ($p < .005$; $\chi^2 = 22.18$).

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TABLE 1
Comparison of Amok and Non-Amok
Homicidal Events

CHARACTERISTIC	AMOK	NON-AMOK
Weapon		
Grenade	18	0
Gunshot	0	8
Other*	2	4
Location		
Least crowded	1	5
Medium crowded	8	5
Most crowded	11	2
Morbidity**		
Range	0-30	0
Mean	6.23	0
Standard deviation	8.74	0
Mortality		
Range	1-16	1-2
Mean	4.22	1.33
Standard deviation	3.72	.50

* Of two amok cases, both used bladed weapons; of four non-amok cases, one used a knife, one used strangling, one used beating, and one used poison.

** Nonmortal wound.

Location. Various locations where the homicides occurred were rated according to their general crowdedness (see table 1). "Least crowded" locations included the forest, vegetable garden, and rice paddy. The home, where several people usually live in two or three rooms separated by bamboo matting, was rated as "medium crowded." Temple festivals, army camps, public streets, and theaters were designated as "most crowded." Amok homicides generally occurred in crowded public places, while non-amok homicides predominated in secluded settings ($p < .006$; $z = 2.91$, by linear regression test).

Morbidity and mortality. Reflecting the choice of weapon and location, morbidity and mortality for each type of homicide showed significant differences (see table 1: for morbidity, $p < .01$; $df = 30$, by Student's two-tailed t test; for mortality, $p < .02$; $df = 30$, $t = 2.46$, by Student's two-tailed t test). In the 12 non-amok cases, dead victims numbered between one and two; no cases where the victim was wounded occurred. On the other hand, the 20 amok cases averaged 4.2 dead victims (excluding the amok person) and 6.2 wounded victims, a mean total of more than ten victims per event.

The Homicidal Person

Demography. The mean age of amok persons was several years younger than that of other homicidal persons (see table 2); statisti-

cal testing indicated that this age difference was significant ($p < .05$; $df = 30$, $t = 2.263$, by Student's two-tailed t test). Also, amok persons were mostly on active duty with the military ($p < .05$; $\chi^2 = 3.880$, by Fisher). Conversely, non-amok persons (who frequently had access to ordnance via their paramilitary role in the militia) tended to work as civilian farmers, merchants, or government functionaries. Other demographic variables (sex, ethnicity, marital status, and education) did not show significant differences.

Social and geographic mobility. Amok persons differed from their fathers in occupation more often than did the non-amok group ($p < .05$; $\chi^2 = 4.44$, by Fisher; see table 2). In addition, amok persons were more apt than non-amok persons to be living somewhere other than their birthplace ($p < .006$; $\chi^2 = 7.82$). While both groups had more education than their fathers, they did not vary significantly from each other on this variable.

Premorbid personality characteristics. The

TABLE 2
Demographic Comparison
of 32 Homicidal Persons

CHARACTERISTIC	AMOK	NON-AMOK
Sex		
Men	20	11
Women	0	1
Ethnicity		
Lao	16	7
Tribal	4	5
Marital status		
Single	8	5
Married	8	6
Divorced	3	1
Widowed	1	0
Education		
0 years	9	5
1-3 years	5	2
4-6 years	6	3
Educational mobility		
More than 6 years	0	2
Same as father*	9	5
Greater than father	11	7
Less than father	0	0
Age		
Range	17-35	20-57
Mean	26.2	33.7
Standard deviation	5.95	12.10
Occupation		
Soldier	15	4
Other**	5	8
Occupational mobility		
Same as father	2	6
Different from father	18	6
Residence at time of homicide		
Same as birthplace	5	9
Different from birthplace	15	3

* Within one year.

** Includes farmer, merchant, student, housewife, and government worker.

TABLE 3
Comparison of Morbid Characteristics
of 32 Homicidal Persons

CHARACTERISTIC	AMOK	NON-AMOK
Premorbid personality		
Personality disorder	10	6
"Normal"	7	6
Unknown	3	0
Precipitating event		
Marital conflict	5	4
Girl-friend problem	3	2
Death of wife	1	0
Gambling losses	4	0
Public argument	4	1
Robbery	0	5
Unknown	3	0
Alcohol usage		
Drinking	15	4
Not drinking	5	8
Postmortem		
Suicide	11	2
Imprisonment*	4	8
Other**	5	2

* One amok case subsequently became psychotic in prison and was released to his family.

** Of five amok cases, four escaped capture and one was imprisoned and later shot while attempting to escape. Of two non-amok cases, both escaped capture.

homicidal persons were assigned by the author to diagnostic categories based on historical reconstructions of their lifetime behavior prior to the homicidal event (see table 3); the assessment of the slayers' cultural peers weighed heavily in this diagnostic categorization. Insufficient data on the previous lives of three amok persons would not allow complete assessment, though no history of psychosis or convulsions was obtained for them.

Both groups had a high rate of personality disorder (emotionally unstable, immature, sociopathic); however, none was so disordered as to have been incarcerated or excluded from the military. Many were also viewed by their reference group as "normal." The two groups did not differ significantly for premorbid state.

Only one person had a psychotic disorder. This amok person (tabulated as "normal" premorbid) lapsed into a psychotic state in prison within hours following the amok event. He has remained thus incapacitated for 12 years. None had a convulsive disorder.

Precipitating event. In most cases the homicidal event could be related in time, place, and social context to a prior event. The two groups did not vary statistically for these events. Marital problems and girl-friend problems commonly occurred before either event. However, gambling losses preceded

only amok, and robbery preceded only non-amok homicide. Public arguments were more common before amok events.

Alcohol usage. Drinking behavior by the homicidal person accompanied amok events more often than it accompanied other homicides (see table 3; $p < .05$; $\chi^2 = 3.880$, by Fisher). Gambling and public arguments always happened in the drinking context, whereas robbery never did. No such trend was noted for domestic or romantic quarrels; these took place in either the sober or drinking state.

Postmortem outcome. Despite similarities in premorbid personality and precipitating event, the groups differed significantly in the events following the homicide (see table 3; $p < .03$; $\chi^2 = 7.5$). Amok persons tended to commit suicide during or soon after the amok event; a few were imprisoned, assassinated, or escaped. Most non-amok slayers went to prison; a few escaped or committed suicide.

Discussion

The homicidal event. The homicidal events themselves suggest that a valid separation can be made for the two types of homicide. Amok generally involves the use of the most destructive ordnance available, such as the grenade. It occurs mostly in crowded places. Data from the Ministry of the Interior in Laos show that this form of homicide is significantly more likely to occur on weekends and between 7:00 p.m. and midnight—times when people leave their individual work tasks and congregate as families, friendship groups, and festival crowds (18). By contrast, other homicides are effected mostly by gunshot in secluded places at times when people are less likely to congregate. The number of victims also powerfully differentiates between the two types of homicide: more than two victims suggests amok, while two or fewer victims suggests non-amok homicide.

The homicidal person. Having shown that amok and non-amok homicides can be separated by objective criteria, we can examine the homicidal persons themselves. Amok persons tend to be younger people, far from their home village, and employed as soldiers (a job unlike that of their fathers). Non-amok persons are older, work at traditional jobs (more like those of their fathers), and live in their home village. One might infer, then,

that amok persons experience more unfamiliar stress while enjoying fewer traditional social resources to assist them through turmoil. Role crisis may also be a factor here, for the younger amok men are often employed at a task alien to them and their fathers.

Insofar as past behavior is concerned, the groups bear a marked resemblance to each other. Some from both groups are described retrospectively by their reference group as mildly deviant in their previous social behavior; others are described as essentially "normal." Thus the people in either group cannot be dismissed as being psychotic. Indeed, only one person became psychotic, and this occurred in jail after the homicide.

Events preceding the homicide show many similarities for both groups. Perhaps an argument can be made that amok occurs almost exclusively following a personal "loss" (i.e., loss of wife, girl friend, money, or "face" in a public argument). Whereas about half of the other homicides followed a loss, the rest resulted from attempts at robbery. Alcohol usage accompanied amok significantly more often than other homicides.

Self-destruction attended amok in more than half the cases. The few instances of psychosis and assassination of the homicidal person also followed amok. Non-amok homicide usually led to imprisonment, although a few persons subsequently committed suicide. In a few cases for both types of homicide successful escape resulted.

Amok hypotheses. Observations of amok from other parts of Southeast Asia and Oceania bear remarkable resemblance to these data from Laos. Kline noted its tendency in Indonesia among "young or middle-aged males who are quite responsible individuals up to the time of running amok" (10). The occurrence of amok among isolated people at a distance from their home was recorded by Amir in North Sumatra (4). Galloway remarked on the premorbid "blow to his self-esteem" among Malays (8); Van Wulfften-Palthe also noted that "an intolerably embarrassing or shameful situation" often preceded amok in Indonesia (14). Burton-Bradley (17) and Gimlette (9) remarked that the amok person, rather than acting randomly, chooses an appropriate series of circumstances that lends itself to maximum mayhem. Zaqirre's cases from the Philip-

pinas were soldiers or veterans with access to military ordnance (3). These and other similarities in the world's literature contribute to a cross-cultural psychosocial profile of amok:

A young or middle-aged adult male, from peasant or lower-class origins and with little formal education, has moved away from his birthplace to work at a job different from that of his father. While he has not had previous mental aberration, his past behavior patterns have evidenced immaturity, impulsivity, poorly controlled emotionality, or social irresponsibility. . . . Following the loss of wife or girl friend, a large sum of money, social prestige (or rarely, for no apparent reason) he suddenly and unexpectedly strews death and injury about himself (19).

While the observations of many investigators over several decades are unexpectedly alike, their explanations for the observed phenomena vary widely. Some authors attribute a greater or lesser proportion of their cases to physical causes, including epilepsy (1, 3, 7), infections such as malaria or syphilis (2, 5, 13), "a grave disease" (5), or a "toxic" process (14). Included in the suggested psychopathologic etiologies for amok are dementia praecox (13), schizophrenia (3), depression (5), "psychosis" (11, 14), fright (5), "sexual conflict" (14), hysteria (2), dissociative reaction (6, 16), "mental upheaval" (9), and "psychical disturbance" (7). National character and racial predisposition have been implicated for this and similar disorders (7, 12, 20). This emphasis on physical and psychological causes for amok may be related to the time and place of examination of the amok person: virtually all subjects have been examined by investigators after the amok event, either in prison or in the hospital. However, this is a markedly skewed sample since, as noted by Kline (10), most amok persons do not survive (or are not apprehended) and cannot be interviewed.

This study, although it relies on retrospective information derived mostly from collateral sources, is nonetheless based on data from a sample of all amok cases—including both cases in which the amok person survives (and perhaps escapes) and those in which he does not survive. Based on the premorbid information available for this sample, the data to support physical and psychopathological etiologies are sparse indeed. Especially in contrast with other homicidal persons, the

determinants for amok appear to be primarily demographic and social.

These findings support the "sociopsychodynamic explanation" proposed by Burton-Bradley (17). None of his amok subjects from Papua and New Guinea showed any evidence of physical disease, epilepsy, schizophrenia, or other mental disorder. All were illiterate men working as farmers, laborers, or artisans—sometimes at a distance from home. Amok behavior followed some slight or insult. Burton-Bradley posited that this violence served as "a means of deliverance from an unbearable situation."

The dynamic of shame in amok has been advanced by Esser (6) and by Weidman and Sussex (15). The latter authors in particular presented a cogent argument for the importance of loss of face in amok and other "culture-bound syndromes" (15). They suggested that loss of social stature may be so overwhelming in some cultural groups that the individual may feel utterly abandoned and helpless when it occurs. Projected rage may then be wrought on all those people in the immediate vicinity.

I would agree with Burton-Bradley (17) that amok may serve as a socially prescribed exitus from an irremediable problem. One might add that the problem may be "irremediable" because of certain crucial social factors (i.e., distance from supportive social groups, inadequate education and enculturation for metropolitan living, etc.). Certainly the rage projected against the social group, as posited by Weidman and Sussex (15), appears only too evident in the behavioral amok message communicated to his reference group by the amok person. Whether amok violence can be linked to a shame hypothesis awaits, in my opinion, the demonstration of shame as a useful cross-cultural concept (rather than merely another decorous but useless concept culture-bound to Western psychiatry).

In sum, these data suggest that social variables are more potent determinants of amok behavior than are psychopathological variables. Youth, role crisis, separation from family and other social support systems, a recent "loss," and drunkenness play a larger role in the genesis of amok than does psychological disorder. Attempts at prevention of such violence must focus on social systems and supportive institutions rather than on traditional early case finding, diagnosis, and

psychiatric treatment.

Conclusions

Amok homicide can be distinguished from other homicide by objective criteria such as the large number killed and/or wounded, crowded location, time of day, and the choice of weapon.

A recent loss (of wife, girl friend, money, prestige) generally precedes amok. Loss of a female companion precedes about half of other homicides; robbery occurs in association with the remainder. Alcohol usage occurs more frequently in association with amok than with other homicides.

Despite similarities in premorbid personality, sex, education, marital status, ethnicity, parental education, and precipitating event, the outcomes for the two groups differ markedly. The non-amok homicidal person kills one or two people, then generally goes to prison. Amok involves an average of ten victims, and the amok person generally commits suicide.

Individual psychopathology does not provide as parsimonious an explanation for amok as does the sociopsychological explanation. Furthermore, the premorbid "pathological" personality characteristics are all too prevalent and mild to offer opportunity for prevention. Preventive measures could perhaps be implemented by stressing the social context of amok.

REFERENCES

1. Adams ARD: Amok, in *British Encyclopedia of Medical Practice*, vol 8. London, Butterworth, 1950-1952, pp 6-10
2. Van Loon FGH: Protopathic instinctive phenomena in normal and pathologic Malay life. *Brit J Med Psychol* 8:264-276, 1928
3. Zaquirre JC: Amuck. *Journal of the Philippine Federation of Private Medical Practitioners* 6:1138-1149, 1957
4. Amir M: Ober eenige gevallen van amok uit Noord Sumatra. *Geneeskundig Tijdschrift voor Nederlandsch-Indie* 79:2786-2798, 1939
5. Ellis NG: Some remarks on asylum practice in Singapore. *J Trop Med Hyg* 4:411-414, 1901
6. Esser AH: Social character as a transcultural approach to neurosis, in *Proceedings of the Third World Congress of Psychiatry*, vol 2. Montreal, University of Toronto Press, 1961, pp 1140-1144
7. Fitzgerald RD: A thesis on two tropical neuroses (amok and latah) peculiar to Malaya, in *Transactions of the Fifth Biennial Congress of the Far Eastern Association for Tropical Medicine*, vol 5. Singapore, Far Eastern Association for Tropical

- Medicina, 1923, pp 148-161
8. Galloway DJ: On *amok*. Ibid, pp 162-171
 9. Gimlette JD: Notes on a case of *amok*. J Trop Med Hyg 4:195-199, 1901
 10. Kline NS: Psychiatry in Indonesia. Amer J Psychiat 119:809-815, 1963
 11. Langness LL: Hysterical psychosis: the cross-cultural evidence. Amer J Psychiat 124:143-151, 1967
 12. Lehmann HE: Unusual psychiatric disorders and atypical psychoses, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins Co, 1967, pp 1150-1161
 13. Van Loon FGH: Amok and latah. Journal of Abnormal Social Psychology 21:434-444, 1927
 14. Van Wulfften-Palthe PM: Amok. Nederl T Geneesk 77:983-991, 1933
 15. Weidman HH, Sussex JN: Cultural values and ego functioning in relation to the atypical culture-bound reactive syndromes. Int J Soc Psychiat 17:83-100, 1971
 16. West LJ: Dissociative reaction, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins Co, 1967, pp 885-898
 17. Burton-Bradley BG: The amok syndrome in Papua and New Guinea. Med J Aust 1:252-256, 1968
 18. Laotian Ministry of the Interior: Statistics for 1970. Vientiane, Laos, Royal Laotian Government, March 1971
 19. Westermeyer, J: Grenade-amok: modern violence in Laos. Presented at the Fifth World Congress of Psychiatry, Mexico City, Mex., Nov 28-Dec 4, 1971
 20. Yap PM: The latah reaction: its psychodynamics and nosological position. J Ment Sci 98:515-564, 1952

DISCUSSION

LESLIE Y. CHENG, M.D. (Flint, Mich.)—I wish to extend my hearty congratulations to the author for a simple and clear presentation of his careful comparative study of amok and other homicide in Laos.

The author describes the person who runs amok as an individual who engages in an occupation different from that of his father, is in his mid-20s, is away from home, and who, after some drinking, rather impulsively kills several people and injures several more people with a more than usually destructive weapon in a crowded place. He usually commits suicide during or soon after the act. The author finds no difference in premorbid personality between the person who runs amok and the one who commits other kinds of homicide. The author concludes that preventive measures can be implemented only by stressing the social context of amok.

Amok, as it was first described by Dennys in 1894, was thought to be seen only among Malays. Later reports showed that amok was seen among Papuans and New Guineans. Nathan Kline, in his 1963 paper on psychiatry in Indonesia (1), mentioned that amok has an incidence as high in individuals of Chinese origin as among the Indone-

sians. With my Chinese background, I would like to suggest a possible relationship between this culturally conditioned abnormal behavior and child rearing in that particular culture.

In the American culture, where a child grows up in a nuclear family of father, mother, and child and where even grandparents are excluded, personality development emphasizes the internalization of social mores and ego ideal in the formation of the superego. Every interhuman relationship during these formative years is highly individualized. Guilt is the important governing emotion, and depression becomes one of the commonest psychiatric illnesses.

In the Chinese culture the nuclear family is replaced by the extended family, where in addition to uncles, aunts, grandfathers, grandmothers, granduncles, and grandaunts on both maternal and paternal sides, the parents' close friends and schoolmates show almost equal interest, responsibility, and support of the child. The severe superego is shared to a marked degree with the group consent of members of the extended family, and guilt is shared by shame.

Even in adult life, the group does not hesitate to exert control on the behavior of an individual and the individual readily and willingly accepts this group control, as is clearly evidenced in drinking customs at feasts. At a table of ten (the usual seating arrangement); when one member shows he has had a little too much to drink by the slight shaking of his hands, overtalkativeness, loudness, or excessive exuberance, the nine other guests will tell him to stop drinking and turn his cup upside down. The group does not hesitate to exert control, and the individual accepts the group censure, usually with a weak protest. The internal conflict with the superego is externalized to a significant degree.

Amok is homicide against a group of people who are often strangers and have no close personal meaning to the person who performs the homicidal act. Non-amok homicide is against an individual who represents a very personal meaning to the one who performs the homicidal act. Burton-Bradley, in an article on the amok syndrome in Papua and New Guinea (2), emphasized the fact that a person who runs amok feels he is placed in a "shameful situation." Dr. Westermeyer describes a person who runs amok as a young person who chose an occupation different from that of his father, was away from home, and tended to commit suicide during the act or shortly thereafter. Here one can see an emotionally immature person who is trying to extricate himself from parental influence, rebels, and gets himself killed.

Langness (3) noted that many people who run amok are then killed by their "fellows." He cited Ralph Linton as saying that when the Dutch made it illegal to kill the amok victim, no matter how many people he had eliminated, and ordered the

amok victim to be netted and sentenced to a life of hard labor, amok disappeared (3, p. 148). Failure to be killed by one's "fellows" during the act appeared to have defeated the psychological need of running amok. Running amok may be seen as a peculiar type of suicide where the individual puts himself in a situation where he is killed by his "fellows," who provide the social mores and ego ideal.

In the American culture only rarely do we witness an occasional individual (who is usually psychotic) hiding himself in a secluded corner and killing innocent strangers who happen to come within his rifle range. This is quite different from running amok. The only instance in which Americans behaved somewhat similarly to running amok was the My Lai massacre. Gault (4) studied returnees from Viet Nam who felt that the enemy were everywhere and were not human. Langner, in his article "The Making of a Murderer" (5), described a young soldier in late adolescence who had a fear of killing his superior; he felt that those whom the Americans were protecting (meaning the Vietnamese) were turning against them.

In a culture where a child is reared in an extended family structure, where many "fathers and moth-

ers" provide the ego ideal for the developing child, it is conceivable that intrapsychic conflict between the ego and the superego is diluted and exists as projected into a realistic external conflict between the individual and the surrounding group of people. This is why "face-saving" is important in such a culture to a degree difficult for Americans to understand. This may also explain why depression and suicide are not as common among the Chinese as among Americans. Running amok may be seen as the externalization of the conflict between the ego and the "social" superego.

REFERENCES

1. Kline NS: Psychiatry in Indonesia. *Amer J Psychiat* 119:809-815, 1963
2. Burton-Bradley BG: The amok syndrome in Papua and New Guinea. *Med J Aust* 1:252-256, 1968
3. Langness LL: Hysterical psychosis: the cross-cultural evidence. *Amer J Psychiat* 124:143-151, 1967
4. Gault WB: Some remarks on slaughter. *Amer J Psychiat* 128:450-454, 1971
5. Langner HP: The making of a murderer. *Amer J Psychiat* 127:950-953, 1971

This Month's Special Section Crisis Intervention

Community Psychiatry and Emergency Service

BY DONALD A. SCHWARTZ, M.D., AUDREY T. WEISS, AND
JAMES M. MINER, M.D.

The psychiatric emergency service at the Orange County (Calif.) Medical Center provides emergency service for periods from one to two hours up to a day or more on the unit. Comparisons were made between patients seen only once over the first four months of operation and those seen more than once during that period. Patients with acute situational problems could be handled on a one-visit basis, often without hospitalization. Those with personality disorders (including alcohol and drug problems) came more frequently and were hospitalized more often.

THE OUT-OF-HOSPITAL emphasis in community mental health has led to the presence in the community of increasing numbers of people who are subject to acute and sometimes repetitive decompensation. The public is supposed to be learning to tolerate higher levels of mental illness in the community, but we have not yet learned to do so comfortably. One consequence is that whoever keeps the

gates of the hospitals is beset with relatives, neighbors, and community caretakers demanding that decompensating people be admitted. The psychiatric emergency service has become the semipermeable membrane of the community mental health system.

Emergency facilities serve not only people in states of emergent decompensation but also a variety of people who come to them in preference to other medical resources. Chafetz and his colleagues (1) have suggested that the hospital emergency service functions as the "poor man's doctor" for a wide variety of health problems. Apart from those who simply find it more convenient to come to the emergency room in the evening than to more conventional medical resources at more conventional times, there are people whose problems have become emergent simply because they have been neglected. In his general review of psychiatric emergencies, Wayne (2) commented on still other patients who are convinced that they only truly need help at times of acute crisis.

It is not easy to define an emergency in objective terms. In a frequently cited paper (3), Ungerleider suggested a simple definition, namely that psychiatric emergencies are situations requiring prompt attention for whatever reasons. A Joint Information Service survey (4) that reviewed a large number of definitions was struck by how few had been carefully thought out. One of the more useful definitions proposed that an emergency was a condition for which immediate treatment would provide urgently needed protection or contribute to the likelihood of recovery. Frazier (5) proposed that an emergency represented a kind of end-stage of exhaustion of

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At the time this study was done, Dr. Schwartz was Associate Professor of Psychiatry, University of California at Irvine, and Chief, Adult Inpatient Service, Orange County Medical Center, Calif.; Ms. Weiss was Social Research Analyst, Bureau of Biostatistics, California Department of Mental Hygiene; and Dr. Miner was Chief, Emergency Admitting Unit, Orange County Medical Center. Dr. Schwartz is now Associate Professor of Psychiatry, University of California at Los Angeles, 760 Westwood Plaza, Los Angeles, Calif. 90024.

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ego defenses in a person attempting to cope with psychological stresses. Trier and Levy (6) attempted to quantify "emergency" in relation to hospital admissions by relating it to the length of time that a patient could wait for hospital admission.

A number of writers have commented on the increasing usage of emergency services (1, 6-11), on their special opportunity to provide useful and innovative services (10, 11), and on their unique potential in the area of community psychiatry (6-9, 12). Trier and Levy mentioned their particular value in the discovery of people at special risk of decompensation, who may be referred preventively to supportive community resources (6). Atkins (7) and Blais and Georges (8) focused on the emergency service as a base for the provision of definitive short-term services, and Bill (13) described an even more comprehensive service including home visits and a telephone answering service operating from a state hospital base. But these latter programs blur the distinction between walk-in crisis services and the emergency room proper.

The medical concept of the emergency room implies that it is needed to prevent serious consequences resulting from the unavailability of immediate professional intervention. An emergency room on that model requires 24-hour operation, the availability of highly trained professionals, and sophisticated equipment. It becomes unduly expensive of money and personnel resources to maintain this kind of service for those who could be cared for as well with less complex facilities.

This paper evolved from the attempt to examine how emergency services could be most effectively used and most economically provided in a newly redesigned psychiatric emergency unit in a university-affiliated county medical center.

The Background

The Orange County Medical Center is the principal teaching hospital for the University of California at Irvine College of Medicine. It includes a psychiatric adult inpatient service with three regular treatment wards containing (at the time of this study) 65 beds in all, plus a special unit known as the emergency-admitting unit (EAU). Both the inpatient service in

general and the EAU have been described in detail elsewhere (14, 15). In brief, the three treatment wards comprised a closed acute unit of 15 beds, an open younger patients' unit of 18 beds, and a general open unit of 32 beds. The EAU was located in the space formerly used for a 14-bed closed treatment ward, which was converted to the specialized emergency usage described immediately below.

Recognizing that the greatest single limitation of the conventional emergency unit is the brief time that it has to make a disposition decision, the EAU followed the lead of some other services (16) by including a holding function in addition to that of emergency evaluation and treatment. The overall mission of the unit was to make the best disposition possible for its patients and preferably to return them to the community rather than to hospitalize them. If holding a patient overnight would permit initiation of treatment that could avert hospitalization, the EAU could hold the patient overnight. If it required an additional day of observation and treatment to determine the truly best disposition, the EAU could hold the patient for that extra day. There was no specific time limit beyond which a patient could not be held on the unit, although stays of more than a day or two were uncommon. However, the unit was not an inpatient ward and its patients were not inpatients, no matter how long they stayed; they were simply EAU patients.

The EAU was the only hospital-based psychiatric emergency service in a county of 1.4 million people. It backed up a service network that included several mobile emergency teams and a crisis intervention center at the hospital in addition to community resources such as private practitioners, social agencies, and police departments.

The holding capacity of the unit permitted hospitalization of many patients to be averted. Moreover, many stays of one to two days, which would have otherwise been defined as hospitalization, were defined instead as emergency evaluation and treatment. To the extent that hospitalization is symbolically a stigmatization of the patient, the EAU patients were spared that stigma. But apart from the artificialities of definitions, the non-inpatient status of the EAU patient made it easy to release him on short notice—as soon as his condition or the environmental circumstances available to him indicated the wisdom

of release. Once officially admitted to a hospital ward, the decision to discharge becomes a formality requiring careful planning, paperwork procedures, and what seems like a major change in the degree of assumption of responsibility by the patient himself. The EAU structure seemed to avoid that inertia and to make discharge easy. In that respect it undoubtedly shortened the stay of patients by hours or days, compared with a short-term inpatient unit on which patients might be held after formal admission as inpatients.

The greatest shortcoming of the EAU was its limited capacity. Many patients had to be transferred to the regular treatment wards or to the state hospital only because the EAU had become too crowded to hold them any longer. Many hospital admissions could have been averted if the EAU were larger. As it was, it provided one holding bed per 100,000 population.

During the early operation of the unit, we were interested in those patients who came to it repeatedly. We had been aware before the EAU was opened that there was a subclientele of the emergency service that came to it repeatedly, but there had been no easy way of collecting data on that group, since psychiatric emergencies were seen along with all others in the main hospital emergency ward. With the opening of the EAU, we decided to begin a systematic collection of data on emergency patients, both those who came only once and those who came repeatedly. We wondered whether these two kinds of patients were mostly like each other or mostly different. If different, would the differences show up in demographic characteristics, in diagnosis, or in other ways? We wondered also whether we would find ourselves treating patients who came more than once differently from those who came only once. Apart from curiosity, we had in mind determining whether multiple admission patients might come from a definable subpopulation that was at special risk and to which we might seek to address ourselves preventively, out in the community, before they came to the EAU in the first place.

The Data

From March 2 to June 30, 1970, a total of 2,252 patients were seen on the EAU. Of these, 1,955 were seen once, 213 twice, 61

three times, 16 four times, four five times, two six times, and one seven times. A 25 percent sample of the patient group was chosen by taking every fourth name from an alphabetical roster. A small number of charts could not be located or did not provide usable data, leaving us with a sample of 552 patients, or 24.5 percent of the total patient group. Of the 552 patients, 485 were seen on the EAU once, 51 twice, nine three times, five four times, one five times, and one six times. The distribution of the sample appeared to be representative of the total population seen. For purposes of comparison, data collected on patients who visited the EAU more than once were taken only from the first admission. Thus, the N for multiple admissions data represents the number of patients who had multiple visits, not the number of visits made by those patients. In many respects, the single-admission subsample and the multiple-admission subsample did not differ significantly from each other.

The Total Sample

The sample was a young one; some 37 percent were under age 25. This compares with approximately 48 percent of the total county population on the 1970 census; however, young children are rarely seen on the EAU (the youngest in the sample was 12 years old and children under age ten are almost never brought there). Thus, within the age range at realistic risk for service on the EAU, teenagers and those in their early 20s are over-represented compared with their population prorates. Single admissions showed a slightly (but not significantly) higher percentage under age 25. The sample was 94 percent white Anglo, five percent white-Mexican descent, and one percent black. (Blacks make up less than one percent of the county population, but whites of Mexican descent are estimated at more than ten percent.) Asian Americans, native Americans, and other ethnic minorities make up slightly more than one percent of the county population but are rarely seen on the EAU; none appeared in this sample.

Of patients admitted once, 32 percent had never been married, compared to 30 percent for multiple admissions. Those admitted once were married in 46 percent of the cases, compared to 40 percent for multiple admissions. Those admitted once were divorced in 12 per-

TABLE 1
Differences in Disposition Between Subsamples

DISPOSITION	SINGLE ADMISSIONS (N = 435)		MULTIPLE ADMISSIONS (N = 67)	
	NUMBER	PERCENT	NUMBER	PERCENT
Hospitalized at Orange County Medical Center	76	15.7	18	26.9*
Transferred to Metropolitan State Hospital	76	15.7	12	17.8
Referred to the outpatient department	139	28.7	13	19.4**
Referred to the community (no specific referral)	146	30.1	15	22.4**
Others and unknown	48	9.8	9	13.5

*Significant at the .05 level using chi square.

**A trend was seen but statistical significance was not reached.

cent of the cases, compared to 18 percent for multiple admissions. The married but separated category was six percent in the case of single admissions and 7.7 percent in the case of multiple admissions. Widowhood appeared in slightly more than four percent of both groups.

Some 55 percent of both groups came to the EAU voluntarily. Median duration of stay on the unit was three hours for single admissions and four hours for multiple admissions, not a statistically significant difference. About 16 percent of both groups remained on the unit for longer than 15 hours. Patients came to the EAU from the community in over 92 percent of the cases in both groups. Multiple admissions were referred from courts in 4.5 percent of the cases, compared to 1.4 percent for single admissions, but the numbers were too small for statistical significance.

Significant Differences Between Subsamples

There were more women than men in the whole sample: 58 percent of the single admissions and 52 percent of the multiple admissions were women, a difference significant at the .05 level by chi square. (This compares with a 1970 census figure of 51.36 percent

women in the county population.) Differences in disposition also reached the .05 level of significance in the case of respective percentages of patients hospitalized at the medical center (see table 1).

The only other area in which significant differences between single and multiple admissions appeared was that of diagnosis. Those with single admissions were more likely to be diagnosed as experiencing transient situational disorders, while those with multiple admissions were more likely to have longer standing personality disorders, including alcoholism and drug dependence (see table 2).

We wondered whether we would find specific patterns of service with multiply admitted patients, such as referrals to outpatient resources followed by hospitalization, or referral first to local hospital resources and later to the state hospital. In fact, there were no consistent patterns of disposition over the sequence of multiple admissions; a variety of patterns were seen and none predominated.

Discussion

The weakest aspect of this study stems from the short period during which data were collected. In order to be designated a multiple admission, a patient would have to be admitted a second time within the four-month pe-

TABLE 2
Differences in Diagnosis Between Subsamples

DIAGNOSIS	SINGLE ADMISSIONS (N = 485)		MULTIPLE ADMISSIONS (N = 67)	
	NUMBER	PERCENT	NUMBER	PERCENT
Transient situational disorder	107	22	8	12*
Schizophrenia	77	16	12	18
Neurosis	56	12	8	12
Nonpsychotic organic brain syndromes	65	13	7	11
Personality disorders, including alcohol and drug dependence	77	16	20	29*
Other and nondiagnosed	103	21	12	18

*Significant at the .05 level using chi square.

riod during which data were collected. In the case of patients admitted initially during the latter part of the study, there was a correspondingly briefer time during which the patient was at risk for a second admission. Some of the patients were known to be people who had been seen in the emergency room prior to the creation of the EAU. The true proportion of multiple admissions would be expected to increase progressively over time. However, it seems likely that the *rate* of this increase would decelerate rather than remain steady or accelerate. Of the 67 patients counted as multiple admissions in this series, 40 had their second admission within a month of the first, and an appreciable number had the second admission within days of the first. In several cases, patients with four admissions had the first two close together and, after not being seen for a time, a third and fourth admission close together. This suggested that some multiple admissions occurred when people came for more than one visit in connection with a single episode of illness or crisis, and others (a smaller number in this study) might have reflected two separate episodes of illness or crisis.

In spite of the fact that our single admission group contained a number of patients who would in time have moved to the multiple admission group, it has seemed worthwhile to report these data. Even in the brief span of a few months, it can be shown that patients with transient situational disorders seem likely to be significantly helped with a single emergency room visit, and that the steady clientele of a psychiatric emergency unit may be expected to contain a disproportionate number of people with personality disorders, including alcoholism and drug dependence. Differential rates of hospitalization seem closely related to differential severity of diagnoses. From the perspective of program planning, these are useful data. Considering the general intent of community psychiatry to avoid hospitalization and to emphasize immediate brief treatment, it is worthwhile to know that emergency facilities can serve large numbers of people with acute emotional storms—and without excessive commitment of scarce resources. It is of even more importance to know that patients with chronic difficulties may be utilizing disproportionate amounts of emergency service time and resources.

For a variety of reasons, then, it would be

well for comprehensive mental health planning groups to seek less expensive ways of serving those with long-standing personality disorders, and to emphasize the use of emergency services for those with acute disorders or acute decompensations of symptomatic illnesses. Although longer periods of data collection would strengthen the conclusions suggested by this study, the preliminary data provided here seem to support the plans of Orange County's mental health program to provide expanded services for those with alcoholism, drug dependence, and chronic life difficulty through resources other than the medical center and its emergency services.

REFERENCES

1. Chafetz ME, Blane HT, Muller JJ: Acute psychiatric services in the general hospital, I: implications for psychiatry in emergency admissions. *Amer J Psychiat* 123:664-670, 1966
2. Wayne GJ: The psychiatric emergency: an overview. *Int Psychiat Clin* 3:3-8, 1966
3. Ungerleider JT: The psychiatric emergency, analysis of six months' experience of a university hospital's consultation service. *Arch Gen Psychiat* 3:593-601, 1960
4. Glasscote RM, Cumming E, Hammersley DW, et al: The psychiatric emergency, a study of patterns of service. Washington, DC, Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1966
5. Frazier SH: Principles of psychiatric emergency management, in *Current Psychiatric Therapies*, vol 9. Edited by Masserman JH. New York, Grune & Stratton, 1969, pp 106-115
6. Trier TR, Levy RJ: Emergent, urgent, and elective admissions: studies in a general hospital psychiatric emergency service. *Arch Gen Psychiat* 21:423-430, 1969
7. Atkins RW: Psychiatric emergency service: implications for the patient, the physician, the family, the hospital, and the community. *Arch Gen Psychiat* 17:176-182, 1967
8. Blais A, Georges J: Psychiatric emergencies in a general hospital outpatient department: some data and a review of the literature. *Canad Psychiat Ass J* 14:123-133, 1969
9. Blane HT, Muller JJ, Chafetz ME: Acute psychiatric services in the general hospital, II: current status of emergency psychiatric services. *Amer J Psychiat* 124(Oct suppl):37-45, 1967
10. Le Poidevin D, Reid AH: Emergency psychiatric referrals to the casualty department of a general hospital. *Scot Med J* 13:306-311, 1968
11. Zusman J: Emergency room psychiatry, in *Current Psychiatric Therapies*, vol 9. Edited by Masserman JH. New York, Grune & Stratton, 1969, pp 182-185
12. Coleman DM, Zwierling I: The psychiatric emergency clinic: a flexible way of meeting community mental health needs. *Amer J Psychiat* 115:980-984, 1959
13. Bill AZ: The effectiveness of a psychiatric emergency

- service. *Delaware Med J* 41:241-249, 1969
14. Schwartz DA: Metamorphosis of a psychiatric inpatient service. *Compr Psychiat* 12:8-18, 1971
 15. Schwartz DA: A non-hospital in a hospital. *Amer J Public Health* 61:2376-2382, 1971
 16. Beahan LT: Emergency mental health services in a general hospital. *Hosp Community Psychiat* 21:25-28, 1970

Rehospitalization Versus Family Crisis Intervention

BY DAVID RUBINSTEIN, M.D.

The author describes the development of a team approach to crisis intervention. By mobilizing family support, the team was usually able to bring about the resolution of the patient's crisis without resorting to hospitalization. This approach has also served to develop the concept that a family can and should share responsibility for the patient's treatment.

THE DEVELOPMENT of family-focused crisis intervention on the Temple Follow-Up Service at Eastern Pennsylvania Psychiatric Institute (EPPI)¹ is part of an intensive effort toward preventing or shortening rehospitalization of our former inpatients. The major thrust of the service, which has treated 853 patients in the past five years, is to discover and utilize therapeutic techniques that will help maintain outpatients in the community. Since we can successfully mobilize interpersonal and environmental resources toward this end, our psychotherapeutic work with patients and their families seeks to help them achieve more effective coping mechanisms under stress and to change existing family patterns that tend to scapegoat the identified patient. In our multidisciplinary setting, we use this focus to train psychiatric residents and involve other staff members in active collaboration.

We had observed that the immediate post-hospitalization period frequently presented a crisis of adjustment for the patient and his family. We identified some other events as likely to signal impending crises: failure to keep follow-up appointments, failure to return for medication after discharge, and any other indications of exceptional stress. The immediate crisis of the return of acute symptoms as noted by the patient or his family was, of course, of primary importance. We reasoned that if we intervened at such times we would be utilizing maximum momentum (considering the crisis anxiety level) to work toward our preventive goal.

The psychiatric literature, which is still scarce on this technique, was nevertheless encouraging in presenting positive results for similar attempts. The Family Treatment Unit at Colorado Psychiatric Hospital, as reported by Langsley and Kaplan (1), used similar techniques and indicated positive findings. In addition, Mendel and Rapport (2) suggested that their study on the decision for psychiatric hospitalization showed that the decision to hospitalize was based on social and attitudinal considerations rather than psychiatric factors. According to them, the absence of social support resources available to the patient was a critical issue in deciding for hospitalization. They suggested that where adequate resources can be mobilized, hospitalization may not be necessary or even useful in the treatment of mental illness.

This paper will describe the development of family crisis intervention at EPPI as part of our continuing effort to keep former patients functioning in the community. I will present case illustrations that provide insight into the pragmatic techniques involved in implementing this project and will include results obtained with chronic patients during this year.

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²The Temple Follow-Up Service is a section of the clinical, research, and teaching divisions at EPPI, organized and cosponsored by Temple University Medical School.

The Crisis Team

A crisis team was set up to include a psychiatric staff doctor, a psychiatric resident, a social worker, and a psychiatric nurse, the last being available for home visiting. Other psychiatric residents and social workers were alerted to consult with the team as they proceeded with follow-up care for former inpatients. The crisis team was available on a daily basis for referral in any crisis situation. The explicit indicators for crisis intervention were the clinically known hazards described above or any other indications of distress from family or patient. Doctors on the admitting service on weekends or evenings were asked to notify the crisis team of any call for help. Each participating resident and social worker was asked to call a member of the crisis team before considering rehospitalization.

Treatment Techniques

As the team was activated, the nurse's home visit frequently became the front line of treatment. Briefed by the referring team as to the particular problems envisioned and backed by the medical crisis staff, her presence in the home established immediate reassurance that the treating facility was ready to help. The nurse, along with other members of the crisis team, has been continually involved in training seminars on family therapy techniques and family dynamics. She is able to bring with her an awareness of the crisis as it is experienced in the context of the family system. She can bring needed medication with her and administer an intramuscular injection of such medication if this is necessary. The nurse is thus able to involve the family immediately in attempting to find solutions to their present dilemma, ruling out hospitalization for the patient. She can help identify and eliminate stresses that are contributing to the patient's present symptoms and behavior.

The family is asked to come into the hospital for a conjoint interview as soon as this is possible. Here they can be seen by other members of the therapeutic team who know them and have worked with them before. The entire intervention is consistently aimed at mobilizing mutually supportive coping mechanisms within the family system in order to resolve the current crisis. Further regression

by the patient is discouraged by giving him active tasks to accomplish. Family members are asked to collaborate in these tasks as it is deemed appropriate. Giving the family and the patient "something to do" provides a way to alleviate anxiety and to communicate the team's own attitude of hope and trust in the family's coping capacities. Any attempt at "scapegoating" is thwarted by encouraging helpfulness and cooperation as the family participates together in "problem-solving."

Conjoint family interviews held in the hospital emphasize the immediacy of the situation and concentrate on meeting needs as they can be identified. Frequently the malfunctioning of the family system can be observed more clearly under this stress. The emotional involvement is so strong that confrontation produces some change in family patterns during the course of the crisis. As cases are continued in follow-up care, regular home visits are available. Experiences during the crisis are shared with the team members, providing continuity and suggestions for further work with the family.

Case Reports

Case 1. One of our earliest attempts at crisis intervention provided results that supported our planned approach. J was a 24-year-old college student who had experienced an acute psychotic episode at age 20 and had been hospitalized five times in the ensuing three years. Her history of episodes was first diagnosed as manic-depressive illness, and then as schizophrenia, catatonic type. In our hospital, we were able to observe the acute onset of a psychotic episode that was catatonic-like and we were able to achieve remission with a short series of ECT. J's remission was rapid and she afterward showed no sign of a thought disorder or other residual factors. Although superficially she was able to relate to others on the ward in a milieu setting, she expressed continuing difficulty with "getting close to people."

It was apparent from social work contact with J's family that the girl was tied into an ongoing conflict between her arthritic mother and alcoholic father. Conjoint family interviews were arranged during her hospitalization and her father was encouraged to enter an intensive short-term residential program for alcoholism. He completed this successfully. A week after J's discharge, after eight months of hospitalization, a crisis call was received from her mother. J appeared to be confused and was not sleeping. This corresponded to her symptoms before previous episodes. The entire family

was brought in that afternoon. It was brought up that J's mother and father had had a tearful, recriminatory battle two days previously. Since former conjoint interviews had already established that her mother would appeal to J for support against her father at these times and that J's disturbance was clearly related to feeling torn and guilty (during her psychotic episodes she verbalized sexual fantasies about her father), the quarrel was identified by the family as a starting point for J's present symptoms.

It was suggested that some outpatient ECT treatment might be helpful, if the family would participate together with J in determining when they would bring her in and also report on her improvement. The mother and father were able to unite with the two younger siblings to provide support for J toward trying to accomplish this without coming back into the hospital. Only two ECT treatments were necessary. Continuing medication provided enough further ameliorative effect. The family was able to include J in their discussions, and the matter of her symptoms was handled with very little anxiety and a great deal of mutual support.

J said afterward that the greatest part of the experience was that her family was accepting her, even "in my craziness," instead of excluding her as they had done in the past. Family interviews were continued on a more intensive basis throughout the year, and J was also treated in group therapy with other outpatients. J is now nearing completion of her college course, which was interrupted four years before. There has been no further episode in 15 months.

Case 2. G, a 44-year-old registered nurse, had had a history of one severe depressive psychotic episode at about age 17. She had been married, has two children (a girl age 15 and a boy age 20), and was divorced from their father after about seven years of marriage. The episode that brought her into the hospital this time occurred a year after her second marriage. She was agitated and depressed, wringing her hands and pacing about. She said she wanted to kill herself but couldn't think how to do it. She defined her desperation as due to her inability to get along with her son, who wanted to move away from home. She also said she couldn't live another minute with her mother-in-law. Her second husband (age 45) had been a bachelor, living with his mother until this marriage. The mother-in-law was described as "over 80, senile, and paranoid."

G was able to make some progress within three weeks and was sent home for a trial visit. Within 48 hours a crisis call came from her husband, who said she was ill again. The mother-in-law had gone to live with her daughter, but G was upset anyway. The family could not identify any reasons for this exacerbation. G was readmitted for a few days,

with the family being interviewed conjointly several times to discuss problems at home. G admitted she was too fussy about the house and too possessive of her children. Some rules for living were established, and further communication was encouraged when problems developed. The family was asked to confront disagreements rather than withdraw from them. G was able to go home and to sustain this remission for about nine months.

A second crisis call came at this time, when the follow-up resident noted that G was exhibiting symptoms of depression again. She was evasive as to whether she had been continuing to take her medication. The nurse went out for a home visit to assess the situation. There she found G considerably upset, screaming at the mother-in-law that "you will have to get out of the house or I will kill myself." G said she could no longer do her household chores. The nurse spoke with her, recognizing her desperate feelings and general fatigue. She helped G prepare lunch. She then left, assuring G that she would be back the next day.

She assigned four tasks to be completed by then: 1) G should call the Health and Welfare Council to inquire about nursing homes for her mother-in-law (her husband had been instructed to apply for public assistance for his mother; this strategy was discussed with the social worker at EPPI, and it was decided that assigning the task of exploring nursing home possibilities to G signaled hope that this could be accomplished and also tacitly supplied approval from "authority" that this was a good plan, hence alleviating guilt); 2) G should take her 15-year-old daughter out to lunch the next day; 3) G should get her hair done at the hairdresser; and 4) G's husband should take her out to a movie. The next afternoon G called to say that all four tasks had been accomplished.

Another home visit from the nurse, during which she helped G prepare dinner and generally offered continuing support for G throughout the day, provided some visible alleviation of symptoms. The doctor was consulted about medication, and G expressed willingness to take it regularly. The family (including the mother-in-law) were then seen conjointly at the hospital and plans for nursing home care were discussed. It was identified that part of G's distress came from her husband's passive way of handling the problem. It was suggested to him that "it's a tough situation to be 'married' to two women at once" and his feelings of inadequacy in this situation were recognized as understandable. He concurred that the nursing home was the best solution. G did not need to be hospitalized and has achieved a sustained remission to date, even though her mother-in-law remains with them since she has not yet been able to be placed in a nursing home.

Case 3. Even in a severe depression after a traumatic event, this patient was maintained in her

home with family and medical support. Contact with the crisis team was made when T, a 32-year-old woman who was a former inpatient, failed to show up for her follow-up clinic appointment. The nurse called the home and made an appointment. The patient called back on the morning of the appointment to say that she didn't want the nurse to come. The nurse went out anyway, explaining that the treatment team felt T needed to talk with someone. T had made plans to rejoin her husband, from whom she had separated. This had been a stormy marriage, with quarrels frequently ending in separations. The husband's job also required a good deal of traveling.

During this visit, T said she thought she would like to go back to the hospital after all, because she wasn't sure she really wanted to go back to her husband. The nurse told her that she couldn't go to the hospital, but that she didn't have to go to her husband either, if she really didn't want that. T said her own mother, with whom she was staying now, was tired of her and didn't talk to her much. She added that she also couldn't stand her mother-in-law, so she would probably go back to her husband, after all. The nurse suggested that she ought to fix herself up a little if she wanted to do that. T decided that was a good idea and proceeded to set her hair. Four days later, T's mother called to say that T had left with her husband and was getting on all right.

One month later, T's mother called to say T was at home and in bed, depressed. T's husband had literally "dumped her" on her mother's doorstep two nights before. The nurse made a home visit and found T curled up in bed, refusing to eat or talk. A call to the doctor reassured the nurse that T could be treated at home if the family would cooperate. The doctor suggested that the family should allow T to continue this extremely dependent role for a while. The family (T's mother, sister, and nine-year-old nephew) fed T and cared for her needs, much as though she were a baby. The nurse returned daily for a few days. Medication was administered intramuscularly as directed by the doctor. When the patient continued to be withdrawn, the crisis team doctor accompanied the nurse on a home visit. Additional medication was ordered. The family was told they could call the crisis team at any time, day or night, if there was any emergency.

The patient gradually improved and began to eat and talk with her mother. She showed an interest in what was going on in the house, and verbalized how much she enjoyed all the attention the family was giving her, since it showed they cared about her. She began to get out of bed and get dressed and slowly take over some of the household chores. Her mother and sister were so pleased with her improvement that they continually reassured T about her successful efforts to be useful. T came into the hospital for her fluphenazine (Prolixin) injections.

The family came in with her, and asked to see the doctor because they wanted to discuss the problem they were having with T's nephew. He was imitating T and when he didn't get what he wanted would use her tactic of getting in bed and crying. The doctor and nurse offered to see the family in regular conjoint sessions to talk about this. Remission has been sustained.

Pitfalls and Problems

During this beginning year of crisis work, it has been possible to identify several areas for improvement of the service. We have noted that, as Mendel and Rapport (2) indicated, the attitudes of the admitting medical staff and other supervisory personnel are often more significant in thwarting our efforts than any other factor. We have run into difficulties that point to the need for changing the basic philosophy of the mental hospital staff. Not many of the psychiatric residents, and certainly not many administrators, are yet willing to accept the risks involved in implementing our plan. Too often the hospital is seen as a "haven"—by the family under stress and by the staff who provide care. Consequently, we meet resistance from both, in relation to our "withholding" attitudes. Although we are willing to supply constant support and care on an outpatient basis, we are still seen as "inflicting the patient" on his overburdened family.

For reasons we have not yet adequately identified, the concept of care and convalescence at home for a mental breakdown is seen as dangerous and invidious. Somehow the idea of "contagion" is introduced into the negative attitudes we encounter. Others in the family indicate they too will "break down" unless the patient is admitted. Frequently, the physician on duty on weekends "forgets" to call the crisis team and, under pressure from the family, admits the patient without any other consultation.

Unfortunately, few mental health professionals see the problem from the perspective of family systems theory. Indeed, our perception of the difficulties does take into account the "contagion" involved in the breakdown of homeostatic family relationships. We intervene with this theoretical approach as our focal point and we are able to observe and work to change destructive family behavior under the powerful spotlight of crisis. We hope that, as we can demonstrate effective techniques,

we can encourage other staff members involved in treatment to participate with us and cooperate on policy issues. We need to expand our family therapy training programs and increase staff knowledge on the theoretical backgrounds, as well as increase their skill in treatment techniques with collaborative therapists.

We have established that treatment team members must have open and constant communication with each other in order to pursue an intensive and consistent intervention during crisis. This points up the essence of the team relationship in such a program, in which various professional disciplines must interact as equal participants with complete disregard of traditional status or hierarchy. Where this is accomplished, our efforts have been pragmatic, creative, and successful. Conversely, where communication has failed, we have been blocked.

We have found that if families are actively involved during the admission process, when hospitalization is decided upon, these families are then prepared to participate in future crises. Such a family-oriented admission procedure, if it were to become standard hospital policy, might prevent many needless hospitalizations. In addition, such a procedure demonstrates a basic philosophical change in staff attitudes—namely, that the family is a resource for the patient, and that the family and the patient do not and indeed must not relinquish responsibility for participating in the treatment and recovery process. Whether this basic attitudinal change will produce positive results for preventive psychiatry—or for medicine in general—has yet to be investigated. That it adds a qualitatively human aspect to institutional procedures can hardly be challenged.

The home visit has proved to be essential in initial crisis intervention as well as in follow-up care. We hope to enlarge our capacity to provide this medical and psychosocial service. Again, the human needs it meets are obvious. In addition, we have seen cost estimates indicating that such service is considerably less expensive than inpatient care. We will continue to investigate and identify family therapy techniques that are useful for this approach. We shall also have to use home and community contacts to develop resources for those patients who have no family to mobilize in their behalf. Further experience and re-

search is essential in this area.

Results

During the six months between July 1, 1969, and December 31, 1969, the pilot period covered in this report, there were 62 admissions to the hospital. During this same period, the crisis team was involved with 27 patients, only three of whom were readmitted. Some important points can be made evident by describing these three patients.

The first, a 25-year-old man who had been hospitalized on three previous occasions, was seen in July by the crisis team. His family was interviewed with him at home. He was given fluphenazine (Prolixin) intramuscularly and for a two-week period was seen at the hospital with his family three times and at home four times. He was then able to go back to work and attended the fluphenazine clinic at the hospital without further intervention until September. At this time he was fired from his job and, although his doctor (not a member of the crisis team) knew he was extremely depressed, the team was not called. He was readmitted.

The second patient was a 40-year-old woman, an Irish immigrant, who has a six-year-old daughter (born out of wedlock) whom she supports. When the patient called her doctor to say she wasn't going to come in for therapy or medication anymore because it was "no use," the crisis team nurse made a home visit. Here the nurse found the patient was listless, depressed, and seemed in extremely poor physical health. The patient stated she had not been eating and was not bothering to cook for her daughter. The child admitted she was missing many meals but was sometimes "eating at the neighbors."

In this case it was evident that, for the sake of the patient and her child, immediate hospitalization was the only practical form of treatment. Kindly neighbors provided temporary care for the daughter. The patient's previous employer was interviewed and, when reemployment seemed impossible, the social worker helped the patient apply for public assistance. In this case, the patient was hospitalized for four weeks, during which time she gained weight and became involved in a vocational rehabilitation program. The nurse has continued home visits as part of her follow-up treatment, engaging mother and

daughter and occasionally the neighbor in these conjoint interviews. The patient's previous hospitalization had lasted five months.

In the third case, the patient, a 30-year-old woman, had taken an overdose of medication, acting out her desperation over a severely disturbed family situation. The family was so openly hostile and rejecting that they succeeded in sabotaging our attempts to intervene. We discovered that the techniques we knew were feeble and inadequate for this family. We admitted the patient, but continued family interviews. We learned a great deal about the family and about ourselves in the course of this four-week hospitalization. We were finally able to get through the hostility and to involve the family in continuing follow-up family therapy. This patient's previous hospitalization was for a period of five months, during which time the family had refused any involvement at all.

Of the 24 patients who were successfully treated on an outpatient basis, five were involved in acute crisis when the crisis team was activated. The others were seen on referral because some hazardous situation had developed. In each case, a home visit was the initial contact and further treatment plans were made on the basis of the observations of the nurse. An interesting footnote here was the referral of a 40-year-old female cerebral palsy victim, who had been an inpatient some years before at a residential rehabilitative school for those with cerebral palsy. This patient was involved in a seemingly hopeless symbiotic relationship with her widowed mother and was so dependent she had never learned to wash herself. The mother had resisted any attempts to involve her daughter in a training program. This time the mother called to ask

that her daughter be admitted to the hospital, since the mother was going to undergo some minor surgery. We used this opportunity to involve other community resources and were able to effect this more appropriate referral, over the mother's resistive protest.

Summary

The Temple Follow-Up Service at EPPI has provided a team approach to crisis intervention with the goal of preventing or shortening rehospitization of former inpatients. In this pilot year we have been able to establish that, through mobilizing family support, we can encourage and sustain the successful resolution of a patient crisis without resorting to hospitalization. We have been able to observe some constructive changes in family systems as we prevented "scapegoating" or the exclusion of family members in an emergency situation. We have demonstrated that family "closeness" can provide support instead of conflict and were able to use this to implement healthier relationships. A by-product of our work has been the development of the concept that a family can and should share responsibility for the patient's treatment. Although we can identify areas for the improvement and needed expansion of this approach, these preliminary results indicate that the continued use of the crisis team will provide a constructive base for preventive psychiatric care.

REFERENCES

1. Langsley D, Kaplan D: *The Treatment of Families in Crisis*. New York, Grune & Stratton, 1968
2. Mendel WM, Rapport S: Determinants for psychiatric hospitalization. *Arch Gen Psychiat* 20:321-328, 1969

Pediatric Hospitalization as Crisis Intervention

BY RICHARD GALDSTON, M.D., AND MICHAEL C. HUGHES, M.D.

The authors describe a follow-up clinic for pediatric patients who have been hospitalized; an attempt is made to transform the acute crisis of hospitalization into a therapeutic relationship aimed at ameliorating intrapsychic and intrafamily problems. This approach has been successful both with patients with demonstrable organic disease and those without such disease.

THE PRESENCE of psychiatric illness among children who have been hospitalized for signs and symptoms of organic disease constitutes one of the more difficult therapeutic problems confronting the psychiatrist in general hospital practice. Hospitalization of a child precipitates a crisis in family life regardless of the cause. The disruption of routine, the anxieties at separation, and the fantasies and fears of illness and its sequelae are some of the factors that acutely threaten both the child and his parents.

When the medical evaluation of the presenting complaint fails to reveal a demonstrable organic disease process consistent with the signs and symptoms, the physician can call a psychiatrist in consultation to establish the likelihood of a psychiatric basis for the complaints. If the psychiatrist demonstrates the presence of an intrapsychic conflict in the child of sufficient severity to account for the complaints, he is then confronted with the need to translate this understanding into some form of relief for the patient.

Often the parents are unwilling or unable to

conceive of a psychological basis for their child's complaints because their own needs and difficulties preclude the acknowledgment of certain desires. The physician caring for the child and the psychiatric consultant are faced with the alternative of avoiding the need to intervene by allowing the child's complaints to go untreated or resorting to the ruse of the placebo, or of forcibly confronting the parents with the diagnosis of psychologic disease when they are not capable of integrating that fact in any fashion that would be useful to the patient.

The Clinic

The Patient Progress Clinic was established at the Children's Hospital Medical Center in Boston five years ago to afford another alternative in the treatment of these cases. The clinic aims to achieve an effective transformation of an ego-alien crisis of illness and acute hospitalization into an opportunity for growth and development. Referral to the Patient Progress Clinic is made by the house officer or attending physician responsible for the patient's care in the hospital after the psychiatric consultant has deemed it appropriate. The referral is made as part of the medical regimen recommended for follow-up care along with medication prescriptions, etc. The clinic is described as a psychiatric clinic concerned with patient progress staffed by experienced psychiatrists meeting in a medical setting, with access to medical and surgical consultation as indicated.

The initial appointment is made within one month of the discharge date, with subsequent appointments at a frequency no greater than monthly and usually at three-month intervals. The duration of the interviews varies from 30 to 90 minutes. The child and his parents are seen together at the beginning of the interview, then the child alone and the parents alone subsequently, with the child joining them at the end.

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The presenting complaint is the usual point of departure of the interview, with the psychiatrist leading the conversation along themes structured to explore the child's accommodation to his life in its behavioral and emotional dimensions. Likes, dislikes, fears, worries, adjustment to changes in school, and the family situation are superficially explored without any reference to their possible relevance to the presenting complaint. The psychiatrist does not attempt to attribute a causal relationship to any of the data and restricts the interview to a general exploration of the patient's progress in relation to the presenting complaint. The interview is actively maintained at the level of conscious sympathetic attention to the problem, with a steadfast avoidance of any premature interpretation of the genetic relevance of intrapsychic conflict to the presenting complaint. In such fashion the persistent interest of the hospital in the patient's progress is deliberately cultivated as the prevailing theme of the transference. Repeated reference is made to hospital personnel who might have figured in the family's past experience of the hospital in order to expand the sense of continuity of concern.

Relating Data to Symptoms

Only after several interviews, extending over three to six months, is a more active effort made to relate the data in any form of an explanation of the symptoms. This requires a steadfast refusal to venture an opinion on the etiology of the complaint with the repeated declaration of "We don't know yet" in response to the parents' frequent demands for an explanation of the basis of their child's symptoms. This deliberate deferment of any interpretation is essential to avoid a premature confrontation with potentially threatening emotions before the relationship with the clinic is sufficiently strong to support the pain and anxiety involved. Often there has been an initially significant improvement in the complaint that is then worsened as a consequence of the interpretation when made; it is important to have a period of well-being to fall back upon to support the continuity of the relationship.

The psychiatrist makes an active effort to avoid reference to the cause of the patient's symptoms in order to reduce the inexorable

burden of parental guilt. He refers repeatedly to the parents' capacity to help their child and emphasizes the need for their active participation in assisting him in the child's treatment. The depiction of the parent as an essential partner in the promotion of the patient's progress is crucial to the procedure, and the psychiatrist actively cultivates the ideal of the good parent with frequent references to himself as a parent and to other parents and children with similar problems. When it appears indicated, the psychiatrist uses advice, recommendations, exhortations, and even admonitions, coupled with psychoanalytic interpretations stated in terms of a sufficiently general nature to allow the parents and the child to ignore them if they cannot tolerate their thoughts in response.

Every effort is made to restore the child to full activity as soon as possible despite the persistence of complaints. The hazards of habitual hypochondriasis, neurasthenia, and addiction to medications as well as the potential loss of schooling and other social contacts far outweigh any possible disturbance to the course of treatment that might result. Restoration of the child's full normal activity in the presence of his persistent complaints can prevail for many months before there is sufficient resolution of the underlying intrapsychic and intrafamilial conflicts to allow for a subsiding of symptoms. In the meanwhile, the child can continue to participate in his life and progress despite his disability. The psychiatrist maintains the expectation of active participation while concurrently exploring the relevance of issues of emotional import to the child's complaint. This attitude of expectant mastery of bodily symptoms and psychological conflict is an example set by the psychiatrist with which the patient and his parents identify; it is essential to the efficacy of the clinic.

Case Reports

The population of the Patient Progress Clinic comprises a wide variety of clinical problems. The patients fall into two broad groups, those with and those without demonstrable organic disease processes.

Case 1. Those with demonstrable organic disease can be exemplified by Thomas P., who was first seen in psychiatric consultation at the age of 12 when he was readmitted to the surgical ward for

the eighth time for reevaluation of persistent fecal soiling. Thomas had been born with an imperforate anus, which was operated upon when he was one day old. The results were far from satisfactory. He suffered from persistent fecal soiling and incontinence and had to wear diapers and change his pants frequently. His school attendance was erratic and was restricted by the need to obtain daily enemas and a change of clothing from his mother. The boy was readmitted because of the persistence of these symptoms and their disabling effect. The surgical service proposed doing a colectomy in order to achieve some degree of continence. Psychiatric consultation had been requested to assess the patient's psychological capacity to tolerate the procedure.

Thomas appeared to be a happy-go-lucky, oafish boy who was in early puberty. He lounged on the hospital bed, making no effort to cover his gaping pajamas even when student nurses walked past. His physical immodesty had been commented upon by nurses, who wondered at his reluctance to take any active part in the application of his enemas. He related in a friendly, compliant fashion but he made a joke out of all the questions posed and seemed unable to take anything about himself or his future seriously. His school performance was barely passable despite evidence of average intelligence and an undemanding school system.

Because of the irreversible nature of the colectomy and the immaturity of the patient relative to his pubescent changes, it was decided to defer any decision about further surgery until adolescence had been more firmly established. Thomas lived in a small town a six-hour drive away, with no psychiatric facilities available. He was referred to the Patient Progress Clinic upon discharge from the hospital and has been followed there over the past four years.

When first seen the month after discharge, he reported a life marked by long hours of watching television and a persistent lack of concern or responsibility for his bowel function. Undergoing enemas, changing clothes, and avoiding accidents when he was away from home dominated his life. He was not doing the perineal exercises recommended by the surgeon. He described all this somewhat sheepishly but without evidence of concern for anything beyond the psychiatrist's reaction, and with no sign of wanting to change anything. His mother concurred in her description of his life at home and expressed dismay and a sense of helplessness and confusion about how to handle her son. Torn by a desire to spare him from embarrassment and a need to sustain the closeness that their relationship afforded her, she recognized that he was becoming increasingly immature compared to the norms for his age.

At the second interview three months later, it was revealed that Thomas had been excused from all physical training and gym classes by the sur-

geon at the parents' request. It was strongly recommended to the parents and Thomas that he participate in physical training like any other boy his age, and a letter of recommendation was sent off to his coach suggesting an appropriately graded regimen of calisthenics. It was hoped that this intervention might promote the development of a more active attitude toward the mastery of his musculature and that he might extend such an approach to include his perineal musculature.

Also, the pattern of repeated enemas was clarified and Thomas was advised to get up two hours earlier to administer his morning enema himself after breakfast in order to avoid the need to interrupt his class to get home, which had been the previous pattern.

At the next meeting three months later, Thomas proudly described his progress in muscle building, displaying the growth of his biceps. That next winter he undertook skiing for the first time and in the spring he described with obvious pleasure his mastery of the sport and the fun he had with other young people.

That summer, instead of continuing to attend a state-supported camp for crippled children, Thomas stayed home. At the urging and with the support of the psychiatrist, he undertook to earn money mowing lawns and doing odd jobs.

In the fall, two years after their first meeting, Thomas' mother confided to the psychiatrist the long-standing marital discord that had permeated their household. She described her husband as a good but isolated man from whom she felt estranged; she wondered if perhaps she had not clung unduly to Thomas as a consequence. At the next interview three months later, Thomas' father drove him to the clinic and the psychiatrist emphasized the several ways in which he might be of help to his son by more actively including him in his own life. The father, who had been deeply threatened by the congenital defect in his son and who felt left out of his care, responded by informing himself of the boy's interests and activities in a much more supportive way. He brought him along on his jobs and included him in his own life, even though there was little change in the marital situation.

At present, after four years of follow-up in the Patient Progress Clinic, Thomas has acquired sufficient control of his bowel function to obviate the need for a colectomy. The strengthening of his perineal musculature through exercise, the personal regulation of his enemas, and dietary discretion have enabled him to master his defect sufficiently to achieve a high degree of continence. His school performance has improved to approximate his potential. His social activity is greatly expanded and he is thinking seriously about himself and his future.

Case 2. The group of patients without demonstrable organic disease can be illustrated by Chloe,

an 11-year-old girl who was seen in psychiatric consultation on the neurological ward to which she had been admitted with the diagnosis of suspected brain tumor. She had suffered the rather abrupt onset of jerking, dystonic movements accompanied by an outcrying and spasm of her left arm and leg. The neurologist thought that each of her signs and symptoms was of a quality most consistent with organic disease of the central nervous system but he was perplexed that the total picture could not be explained by any single organic disease entity and would require the simultaneous occurrence of several lesions.

The patient was a strikingly pretty prepubescent girl with a vacuous stare punctuated by a left-sided grimace with simultaneous writhing of the right side of her body accompanied by a groan. The seizure lasted 30 seconds, after which her face and body resumed repose and she spoke affably as if nothing were amiss.

Despite the organic appearance of these episodes, with the form and distribution of signs reminiscent of the hemiparesis following cerebrovascular accident, the countenance, history, and personality of the child were much more consistent with the diagnosis of a conversion symptom in a child with a hysterical character structure.

The psychiatrist ascertained that the child's mother worked as a physiotherapist, traveling to nursing homes around the state, and that the patient had recently asked (and was allowed) to accompany her on her rounds. It seemed most likely that her signs and symptoms represented her identification in mimicry of the patients who had captured so much of her mother's attention.

Repeating to the child and her parents that there was nothing wrong with her body and that she could and should resume normal activity, coupled with a program of physical therapy, enabled her to resume most of her motility before discharge from the hospital.

The parents were adamant in their refusal to entertain the possibility of an emotional basis for their daughter's complaints. Having already had the child in two hospitals, they were content not to go to another hospital, but they insisted that the condition must be due to some unrecognized central nervous system disease. Despite this contention—which persists to the present—they accepted referral to the Patient Progress Clinic. In a follow-up interview it was clarified that Chloe had pursued a vigorous program of highly exhibitionistic activities: dancing, gymnastics, cheerleading, ballet, and horseback riding. Despite the protests of mother and child, the parents acted to curtail the frantic pace with which these had been pursued and restored some restraint to the excitement that had prevailed around the use of Chloe's body.

A subsequent interview revealed a household split along incestuous lines in which Chloe served as her father's confidante in an exclusive bond from

which it appeared she was attempting to escape through her symptomatology. The parents were advised to realign the distribution of their attentions, and the child was urged to cultivate a life away from her parents; this was done without any comment upon the bearing of these recommendations on her symptoms. Three months later the child was free of symptoms, although her character structure subsequently remained vulnerable to the formation of hysterical features. The parents continued to insist that the child was a paragon of mental health and steadfastly refused any psychiatric attention for her or themselves.

Discussion

There are a significant number of children whose hospitalization mobilizes intrapsychic and intrafamilial conflicts that present themselves in the form of a crisis of physical symptoms and signs. The ultimate resolution of their conflicts depends upon effective intervention, including the recognition and identification of the constituents of the strife. In an article on hospitalization, Solnit (1) observed: "A crisis for the mother and child can advance or hinder the child's development." The Patient Progress Clinic was established to provide a form of psychiatric treatment for a pediatric population who would not receive attention otherwise. These patients do not accept referral to a regular psychiatric clinic for a wide variety of reasons, all of which ultimately derive from their predilection to experience psychic stress as bodily sensation. By means of acute intervention at the time of hospitalization, with prolonged but infrequent follow-up, a supportive relationship with a vigorous transference can be developed. The psychiatrist who is willing to defer early insights in favor of an emphasis upon the patient's symptomatic improvement will ultimately be rewarded with the development of understanding by the patient and his parents, but only when they are ready. A willingness and ability to approach the patient and his parents at that level of psychic functioning with which they are reasonably comfortable is essential to this technique, which aims to resolve acute bodily suffering into its psychic components in order to afford relief.

Wolff (2) observed that "when children with known psychiatric disorders are compared with normal controls we find that disturbed children have been in hospitals much more often and for much longer than other

children in the community" (p. 62). Prugh and associates (3) concluded an extensive study of children in the hospital with the comment that "the preventive possibilities of the work of pediatricians—and other professional groups—in regard to the handling of post-hospitalization reactions seems clearly evident."

The Patient Progress Clinic is an attempt to realize the preventive possibility of pedia-

tric hospitalization by transforming the acute crisis into a therapeutic relationship.

REFERENCES

1. Solnit AJ: Hospitalization. *Amer J Dis Child* 99:155-163, 1960
2. Wolff S: *Children Under Stress*. London, Lane, 1969
3. Prugh DG, Staub EM, Sands HH, et al: A Study of the emotional reactions of children and families to hospitalization and illness. *Amer J Orthopsychiat* 23:70-106, 1952

Crisis Intervention and Prevention of Psychiatric Disability: A Follow-Up Study

BY J. BARRY DECKER, M.D., AND J.M. STUBBLEBINE, M.D.

Two groups of young adults were followed for two and a half years after their first psychiatric hospitalizations. The first group received traditional modes of treatment; the second group was hospitalized after the institution of a crisis intervention program. The authors compared the outcomes of the two groups to test whether crisis intervention could reduce long-term hospital dependency without producing alternate forms of psychological or social dependency. They found that crisis intervention did reduce hospitalization throughout the second group's follow-up period without an increase in other indices of disability.

CRISIS INTERVENTION as the rationale for a clinical psychiatric technique was first clearly presented by Eric Lindemann in 1944, in his description of his interventions in the course of grief after Boston's Cocoanut Grove fire (1). The appeal of this concept lies in the possibility of prevention. If crises in which adaptational success or failure hangs in the balance can be identified and favorably influenced at the time they occur, there is a great advantage over later treatment of the residual effects of adaptational failure on ego

development. As elaborated and popularized most notably by Gerald Caplan (2), the concept of prevention by crisis intervention has been the rationale for a large part of the literature and activity in the growing field of community mental health.

Until 1969 all emergency and involuntary psychiatric hospitalization in the City and County of San Francisco took place at San Francisco General Hospital. In 1967 crisis intervention replaced emergency detention at San Francisco General Hospital. Among the reasons for this change was a clinical judgment that the process of detention, diagnosis, and disposition was itself a pathogenic experience. Helplessness and institutionalization became solutions for the patient's developmental and adaptational stresses. Long-term prevention called for a treatment process organized to help patients regain control of events and emotions in the hours and days surrounding a psychiatric hospitalization. The change in the nature of psychiatric emergency treatment in San Francisco has been in effect over a long enough period that we may begin to compare the long-term clinical results of crisis intervention with the effect of diagnosis and inpatient treatment on the course of illness of large numbers of patients.

Method

We shall compare the outcome over a two-

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and-a-half-year period for the 315 young adults who had their first admission to San Francisco General Hospital for emotional disorder during the last six months in 1964 with that for the 225 who were first admitted during the last six months in 1967.

For patients with disorders requiring acute, intensive 24-hour care, the possibility existed that crisis intervention, far from preventing permanent personality damage as we assumed, actually only prevented the intensive long-term inpatient treatment appropriate to a severe mental disorder. If so, we would expect that eventually all incidence of severe disability due to mental illness in the form of institutionalization, death, or dependency on welfare would become greater in a group treated with crisis intervention than in a similar group provided long-term inpatient care. Since the 1967 group was composed of those who remained after crisis intervention had been used with as many patients as possible, one might expect that their outcome would be biased toward showing greater pathology.

The Emergency Detention System in 1964

In the detention wards of 1964, patients were most commonly admitted on the initiative of the police and were observed for several days. They were examined and diagnosed medically and psychiatrically by students, interns, and residents, with each case reviewed daily by staff psychiatrists. When inpatient treatment was needed, this was arranged for either locally on the inpatient treatment units at San Francisco General Hospital or Langley Porter Neuropsychiatric Institute, or on the acute treatment units of one of the distant state hospitals serving San Francisco residents.

The Crisis Intervention System in 1967

By 1967 the Psychiatry Service at San Francisco General Hospital was organized into four clinical units, each with three interdisciplinary teams. At any given time throughout the day one team was on "intake" and received all patients coming to the hospital for psychiatric reasons.

In 1967 the responsibilities of a psychiatrist were shared in an interdisciplinary team with a nurse, a social worker, several technicians, house staff, and other trainees. The team used all its technical and personal resources in all available modalities of care to reestablish in-

dependent functioning of the individual as quickly as possible. As soon as the patient appeared at the hospital, a rapid but comprehensive evaluation was made by the team, which could offer a wide range of degrees and modalities of treatment, including 24-hour inpatient care. With a few carefully considered exceptions, every effort was made to avoid allowing a patient in crisis to develop a stable adaptation to 24-hour-a-day institutional care.

The team members had first to create a situation in which communication could be established between the patient and the staff, then to use this relationship to motivate and assist the patient to reestablish a role in a social network outside of the treatment situation. This required dealing immediately with a broad range of medical, social, financial, and legal problems simultaneously with the motivational and defensive elements relevant to the patient's ability to resolve the crisis. Each team had patients in all phases of treatment and could move patients from one type of treatment to another as a crisis developed and was resolved and still sustain therapeutic interpersonal bonds. The goal is suggested by the term "mental health expeditor," which was used to describe paraprofessionals trained to treat patients in the manner described here (3). Should further crises occur, the patient would again be treated by the original team.

Follow-Up Method

All psychiatric admissions to San Francisco General Hospital (SFGH) for the two study periods (the last six months of 1964 and the last six months of 1967) were screened for birth date. The SFGH charts were obtained for all patients over the age of 18 and under 31. Patients with prior psychiatric admissions to SFGH or primary discharge diagnoses of organic disorder were then excluded. The remaining patients comprised the subgroup of the San Francisco young adult population having their first admission to SFGH for a functional psychiatric disorder (315 in 1964; 225 in 1967).

This hospitalization is referred to as the index hospitalization; it extended from the day of admission until it was terminated either by discharge or by transfer to an inpatient treatment unit. A record was made from the charts

TABLE 1
Comparison of Monthly First Admissions of
Patients Age 18-30

CATEGORY	JULY-DEC. 1964	JULY-DEC. 1967	CHANGE
Men			
With positive history*	7.8	8.8	+1.0
Without positive history	16.5	13.1	-3.4
Women			
With positive history*	9.0	4.1	-4.9**
Without positive history	19.1	11.3	-7.8***
Total	52.5	37.5	-15.0***

* A history of prior psychiatric hospitalization elsewhere or some prior period on welfare.

** p < .05

*** p < .01

of these patients of any history of prior hospitalization elsewhere, as well as all subsequent SFGH psychiatric admission and discharge dates.

The index hospitalization list was checked against the central index of the California State Department of Mental Hygiene to obtain hospital admission and discharge dates for all state hospitals, including the two neuropsychiatric institutes. Days on leave were not counted as hospital days.

The list was then checked against the central registry of the San Francisco Department of Social Services to determine dates for onset and discharge of all patients from either Aid to the Totally Disabled (ATD) or Aid to Families with Dependent Children (AFDC).

The list was then checked against the San Francisco Death Registry and, for those who had died, the death certificate was examined for cause of death.

Whenever data on file were incomplete or ambiguous, the appropriate hospital or social service chart was examined to complete the data.

Follow-up data were calculated from the discharge date of the index SFGH hospitalization until May 1, 1967, for the 1964 group, and until May 1, 1970, for the 1967 group. The follow-up period ranged from two years and four months to two years and ten months, depending on the initial admission date.

Results

The average number of young adult first

psychiatric admissions per month decreased from 52.5 in 1964 to 37.5 in 1967. This change was probably not due to a decrease in the population of young adults in San Francisco at risk of a psychiatric hospitalization, since the 18-34 age group in San Francisco increased from 165,274 in the 1960 census to 204,896 in 1970. The probable cause is suggested by table 1, which shows that the difference in admissions was almost entirely due to a reduction in the rate at which women were hospitalized, particularly those with no history of prior psychiatric hospitalization or of being on welfare.

The reason for these differences is clear to those who work in general hospital crisis or emergency settings. Young women tend to present psychiatric emergencies in greater numbers than men, but in our experience are much more likely to have relatives, friends, and therapists interested in them who are, or can be, involved with the crisis. If diagnosis must precede treatment, such patients must be hospitalized if the symptoms are serious, and in 1964 women were hospitalized in greater numbers than men. Where crisis mastery is the issue, and a social network is available at the initial contact, the relative isolation and protection of the hospital may be attractive but is often contraindicated. The result is that fewer women were hospitalized in 1967 than in 1964, while the number of men hospitalized changed relatively little.

As a result of the change in criteria for hospital admission, the group of patients hospitalized in 1967 was smaller and of a different composition from that in 1964. Table 2 shows the composition of the two groups, with a relative shift toward men and chronicity, due to the lower number of young women admitted as a result of crisis intervention at the initial contact.

TABLE 2
Composition of 1964 and 1967 Groups of
First Psychiatric Admissions of Young Adults

CATEGORY	1964 (N=315)		1967 (N=225)	
	NUMBER	PERCENT	NUMBER	PERCENT
Men				
With positive history	47	14.9	53	23.6
Without positive history	99	31.4	79	35.1
Women				
With positive history	54	17.2	25	11.1
Without positive history	115	36.5	68	30.2

TABLE 3
Follow-Up of 1964 and 1967 Groups

CATEGORY	1964 (N=315)	1967 (N=225)
Follow-up hospitalizations	193	86*
Readmissions**	154	127
Hospital days per patient	131.2	61.1
Total hospital days	41,552	13,754
Receiving welfare support	35	29
Committed suicide	6	1

* $p < .01$ by chi square.

**Excluding those transferred after the initial hospitalization.

Initial Hospitalization and Disposition

The 315 patients in the 1964 group spent an average of 5.9 days in their first SFGH psychiatric hospitalization. In 1967 the 225 hospitalized patients averaged 11.5 days¹ during the inpatient phase of crisis intervention. Following this, 138 patients (44 percent) from the 1964 group were transferred for further inpatient treatment. In contrast, 28 patients (12 percent) from the 1967 group were transferred for inpatient treatment ($p < .01$ by chi square).

Follow-Up Psychiatric Hospitalization

Over the two-and-a-half-year follow-up, 193 of the 325 patients in 1964 (60 percent) spent some period of time in psychiatric hospitals (including transfers) after the initial SFGH hospitalization (see table 3). Only 86 patients from the 1967 group (34 percent) spent any additional period in psychiatric hospitalization ($p < .01$ by chi square).

Readmissions

The total number of subsequent psychiatric admissions (excluding transfers) for the 1964 group in the follow-up period was 154, or 0.49 per patient. The corresponding figures for the 1967 group are 127, or 0.56 per patient.

Hospital Days per Patient

The marked reduction in the proportion of patients treated with long-term inpatient care in 1967 without a significant change in the readmission rate continued throughout the follow-up period. As a result, the average number of days spent in psychiatric hospitals

from the first day of the initial SFGH hospitalization and during the entire two-and-a-half-year follow-up period fell from 131.2 days for the 1964 group to 61.1 days² for the patients first admitted in 1967.

Hospitalization

The cumulative effect of the reduction in first admissions, and the reduction in the average number of hospital days for those who were admitted, resulted in a reduction from 41,552 total hospital days for the 1964 group to 13,754 hospital days for patients first admitted in 1967.

Welfare

Out of the group of patients first admitted in 1964, 35 or 11 percent received Aid to the Totally Disabled or Aid to Families with Dependent Children during the two-and-a-half-year follow-up period. Twenty-nine or 13 percent of the 1967 group received ATD or AFDC.

Suicide

Six of the patients first hospitalized in 1964 died during the follow-up period—all by suicide. There was only one death during the follow-up period for the 1967 group, also by suicide. While we feel the drop in numbers of patients committing suicide is not a coincidence, the numbers are too small to achieve statistical significance.

Discussion

Possibly because of the great number of methodological problems in psychiatric field studies in general (4), it has been very difficult to determine whether crisis intervention programs have actually been effective in the prevention of chronic mental illness. Short-term studies, such as outcome in surgery, have repeatedly shown clinical benefits from crisis intervention techniques (5-7). Outcome studies in which psychiatric hospitalization has been averted have shown good results (8-10). In neither case, however, is it clear that we are following patients likely to have gone on to

¹ Distribution does not meet the criteria of normality for statistical tests of difference since there were only small numbers of patients in both groups with extended hospital stays.

² Distribution of hospital days per patient does not meet the criteria of normality for statistical tests of difference since there was such a small number of patients in both groups with large numbers of hospital days.

states of severe deterioration.

Long-term studies of a population at risk of mental illness have shown reductions in the number of people requiring chronic hospital care as a result of the operation of a community mental health center (11), but the change in the patient's location from hospital to community does not tell us whether disability has been lessened. Military psychiatry has developed a technique and rationale very similar to crisis intervention with apparently excellent preventive results (12). However, despite some inviting analogies between urban life and armed combat, the degree to which the military experience can be generalized to civilian psychiatry is quite uncertain.

In previous papers, a massive shift from state hospital treatment to community programs in San Francisco has been described (13, 14). This shift has been administratively possible because of the development of clinical methods of crisis intervention for all patients at risk of psychiatric hospitalization in San Francisco since 1967. Since 1968 this same approach has been decentralized in mental health centers throughout San Francisco. While the programs of the local mental health centers are quite varied, operation of the system as a whole depends on the effectiveness of crisis intervention in all the centers in preventing or abbreviating forms of illness requiring 24-hour institutional care. In this way personnel and other resources required for institutional care could be shifted into a broad range of community services designed to reach people at risk of hospitalization earlier and to reach some people who have less incapacitating disorders.

In addition, we conclude from the results of this study that the anticipated reduction of psychiatric inpatient treatment was achieved by the crisis intervention treatment program. Fewer patients were hospitalized and those who were spent less time as psychiatric inpatients. This reduction in hospitalization was achieved *without* paying a price in alternative forms of disability, such as increased readmission rates or increased support by welfare, and indeed with a reduction in the number of patients who later committed suicide. More importantly, these results were obtained with patients who as a group were initially somewhat more chronically disabled and socially isolated than the comparison group.

Social adaptation cannot be equated with

mental health in a simple way, but neither can hospitalization: be simply equated with good treatment of mental disorder. It is not the authors' contention that psychiatric hospitalization is bad. We do feel that, if hospitalization is used with the restraint appropriate to any potent but dangerous remedy, human beings can show a remarkable capacity for recovery from the gravest of emotional crises. Young adults facing adaptational failure rarely need or benefit from an adaptation to the infantile life of prolonged institutional care. With a treatment program aimed at rapid reduction of helplessness and infantilism, patients do not show a tendency to eventually require institutionalization or to substitute other forms of helplessness, such as multiple hospital admissions, dependence on welfare, or suicide.

REFERENCES

1. Lindemann E: Symptomatology and management of acute grief. *Amer J Psychiat* 101:141-148, 1944
2. Caplan G: *Principles of Preventive Psychiatry*. New York, Basic Books, 1964, pp 26-55, 89-112
3. Hansell N, Wodarczyk M, Visotsky HM: The mental health expediter. *Arch Gen Psychiat* 18:392-399, 1968
4. Dohrenwend BP, Dohrenwend BS: *Social Status and Psychological Disorder*. New York, Interscience, John Wiley & Sons, 1969, pp 95-109, 110-130
5. Lazarus HR, Hagens JH: Prevention of psychosis following open-heart surgery. *Amer J Psychiat* 124:1190-1195, 1968
6. Skipper JK Jr, Leonard RC: Children, stress, and hospitalization: a field experiment. *J Health Soc Behav* 9:275-287, 1968
7. Egbert LD, Battit GE, Welch CE, et al: Reduction of postoperative pain by encouragement and instruction of patients. *New Eng J Med* 270:825-827, 1964
8. Langsley DG, Flomenhaft K, Machotka P: Follow-up evaluation of family crisis therapy. *Amer J Orthopsychiat* 39:753-759, 1969
9. Mendel WM: Effect of length of hospitalization on rate and quality of remission from acute psychotic episodes. *J Nerv Ment Dis* 143:226-233, 1966
10. Pasamanick B, Scarpitti FR, Dinitz S: *Schizophrenics in the Community: An Experimental Study in the Prevention of Hospitalization*. New York, Appleton-Century-Crofts, 1967
11. Gruenberg EM, Snow HB, Bennett CL: Preventing the social breakdown syndrome. *Res Publ Ass Res Nerv Ment Dis* 47:179-195, 1969
12. Hausman W, Rioch DM: Military psychiatry: a prototype of social and preventive psychiatry in the United States. *Arch Gen Psychiat* 16:727-739, 1967
13. Stubblebine JM, Decker JB: Are urban mental health centers worth it? *Amer J Psychiat* 127:908-912, 1971
14. Stubblebine JM, Decker JB: Are urban mental health centers worth it?: part II. *Amer J Psychiat* 128:480-483, 1971

Hotlines and Youth Culture Values

BY PAUL TOROP, M.D., AND KAREN TOROP, M.S.S.S.

Hotlines represent a coalescence of the traditional and the counter-culture models of crisis intervention. Hotline staff members who are oriented toward counter-culture values tend to relate easily to callers in a nondirective, nonauthoritarian manner. But in their efforts to be accepting and informal, they have difficulty avoiding sadomasochistic entanglements with some chronic callers. Even though the younger volunteers tend not to be predisposed to seek professional supervision in learning to manage these difficulties, they are able to use such supervision effectively.

WHEN THE Suicide Prevention Center of Los Angeles was established 12 years ago, facilities for crisis intervention by telephone were unusual. During the past decade such psychiatric emergency centers have sprung up throughout the country. The most recent phenomenon in this development is the "hotline," which provides, for persons experiencing any kind of emotional crisis, immediate access by telephone to an anonymous, sympathetic listener. The first hotline was started at Children's Hospital in Los Angeles in 1968. There are currently about 500 hotlines in the United States (1), and many of these have been initiated within the past two years.

We provided professional supervision and consultation for the Alexandria (Va.) Hotline, which at the time had been in existence for less than one year. This hotline, like most hotlines, uses nonprofessional volunteers as listeners. It was our goal to help maximize the effectiveness of this nonprofessional staff.

Implicit in the formation of many hotlines are the values and beliefs of the current youth

counter culture. These values can contribute to the success of hotlines. However, some of these values tend to lead young hotline volunteers into difficult relationships with certain callers. In these situations professional supervision can be extremely useful, but counter-culture beliefs about professionals often work against the acceptance of supervision. We found it a challenge to use our knowledge and experience in a manner that both professionals and nonprofessionals would agree is helpful to the caller and to the volunteer. In this paper we will provide a perspective on the development of hotlines and describe our work in supervising young hotline volunteers.

Historical Perspective

Hotlines appear to have origins in traditional and counter-culture models of crisis intervention. The crisis intervention theories of Lindemann (2) and Caplan (3) provided a theoretical basis for the establishment of early psychiatric first-aid centers. The original centers, such as the Los Angeles Suicide Prevention Center, were staffed by mental health professionals. When it became necessary to employ nonprofessionals to meet the need for service that would be available seven days a week, 24 hours a day, these persons were carefully selected, intensively trained, and closely supervised. Thus a hierarchical, highly structured organization characterized the original psychiatric emergency centers (4-6).

The hotlines tend to manifest some of the characteristics of a later development in the history of crisis intervention: the experiences of professionals and nonprofessionals who in the late 1960s began to organize free clinics, houses for runaways, drug rescue groups, and other informal or communal help centers. The model here emphasizes openness, acceptance, and unstructured relationships with others as therapeutic. In such settings each staff person, depending more on his life experience

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than on his academic credentials, is a potential source of guidance for other personnel. This tends to reflect a view of professional expertise as authoritarian or irrelevant to the experiences of young people.

As might be expected, the staff person in this model opts for a free flow of feelings and experiences between himself and the patient or client. He is uncomfortable with the methods of the more traditional crisis intervention worker (e.g., formulating a diagnostic impression, establishing a working relationship, and developing a treatment plan).

The Alexandria Hotline

Hotlines may reflect characteristics of both the traditional and the counter-culture crisis intervention models. The Alexandria Hotline, for example, was initiated by professionals and established community leaders, but uses as staff a generally young group of volunteers who are enthusiastic about talking with troubled persons. It is coordinated by a mental health professional and uses other professionals for training, supervision, and backup services. Decision-making powers rest with a small group of professionals and community leaders. The training of volunteers is neither as rigorous as that of the traditional crisis intervention centers nor as informal as that of the counter-culture model.

The Alexandria Hotline's initial training program involved two sessions of two and one-half hours each. Volunteers were selected to attend on the basis of their written applications, which contained references and a statement of their reasons for wanting to work on the hotline. Instruction in crisis and suicide theory and discussion of nondirective interviewing techniques took place in a large group of approximately 60 applicants. Small groups of ten to 12 applicants then participated in role playing under the direction of a professional.

The mental health professionals and the hotline organizers screened volunteers informally by observation during this initial training program and the early days of the hotline. Once accepted, volunteers were expected to attend a monthly in-service training session, which consisted of either a small group of about ten, led by an experienced volunteer or by a professional, or a meeting of all volunteers, usually addressed by a professional.

During the early weeks the coordinator or one of the hotline organizers was in the office to provide supervision as needed. Later, the presence of a veteran volunteer during most four-hour shifts served this function. Supervision was also available at the request of the volunteers, as was immediate psychiatric backup by telephone. Volunteers generally felt free to ask advice or share their feelings in the informal setting of the office, but many were resistant to attending the in-service training. We feel that this was due in part to their negative feelings about professional supervision. Some of these feelings will be discussed later.

It seemed to us that this selection and training process was adequate to produce a dedicated beginning staff, one capable of handling most calls with empathy, common sense, and originality. A self-selection process during the initial training period also served to weed out persons with inappropriate motivations and lack of sensitivity to themselves and others. It was felt that much of the learning would have to be done on the job and that an intensive course in factual material would not be effective and might, in fact, increase the applicants' anxiety. (Concrete information regarding techniques of handling specific emergencies was posted on the walls of the office, and information about drugs and other problems was also available for quick reference.)

The Alexandria Hotline's screening criteria differed from that of some other hotlines with a greater counter-culture orientation in that the latter tend to look for the applicant's degree of "radical awareness" as well as his level of emotional maturity and ability to respond to callers' needs. For example, one hotline, which uses a comprehensive telephone screening interview before inviting applicants to orientation sessions, asks the interviewer, "Does prospective new volunteer seem to have an adequate knowledge and understanding of 'why' there are 'alternative' life-styles?" and "What kind of life-style [does the prospective volunteer] have?" (1).

The Alexandria Hotline did not require such awareness; it was, however, apparent that the younger volunteers shared an understanding of and some participation in alternative life-styles.

In its first six months of operation the Alexandria Hotline trained more than 200 volunteers and received more than 13,000 calls.

It is estimated that more than half of the volunteers have been under age 30, with perhaps one-fourth under 20 years. The minimum age is 18. The content of the calls ranged from parent-child conflicts to drug problems to potential suicides.

Supervision of Volunteer Staff

In the early training sessions the professional staff placed much emphasis on a nondirective approach to callers. The anticipated problem—that the volunteers would hasten to give advice, authoritarian solutions, or a barrage of referrals—did not materialize as a critical one, particularly with the younger staff. In fact, the greatest difficulties seemed to arise out of the very accepting and nonjudgmental approach described earlier as characteristic of counter-culture crisis intervention.

It became apparent after several months that volunteers were having difficulty with callers whose reactions to their acceptance and warmth were not foreseen in either the volunteers' initial training or their expectations of their role. These callers, many of whom were repeaters, were able to manipulate the volunteer in such a way that the focus of the call became the volunteer's reaction to the maneuverings of the caller.

For example, one repeater who presented himself to the predominantly white volunteers as a young black man (but who was actually white) accused them of indifference or racism when they wearied of his paranoid tirades, became annoyed with his abusive language, or refused to meet with him. Another chronic caller, who was quite psychiatrically sophisticated, projected his feelings about his therapist onto the volunteers, expertly provoked their anger, then became enraged at them and either threatened suicide or hung up. A third repeater spoke in depressed tones about his inability to articulate his problem, subtly encouraging (female) volunteers to question and reassure him, while he masturbated throughout the call.

The challenge of such callers has been noted in reports of the traditional crisis intervention centers (4), and it is certainly not unknown to social agencies, psychiatric clinics, and hospital emergency rooms. These callers are the persons who in other circumstances are often diagnosed as borderline or overtly

psychotic or as dealing with the world through perversions.

However, to the young hotline volunteer they present a particular dilemma. The social-psychological set of many of these young volunteers tends in the direction of what Charles Reich has described as "Consciousness III" (7). Some of the characteristics noted by Reich are the belief in the uniqueness and absolute worth of each individual and the refusal to judge anyone else. It is very difficult for a person with this orientation to deal with the feelings aroused by repeated experiences with a manipulative, often sadistic caller.

The hostility, guilt, and sense of failure the volunteers felt was at times overwhelming. And yet, turning to a professional consultant is difficult for someone who is trying to organize his or her life away from the "old-style" relationships of subservience and authority. Furthermore, the professional is distrustful for his tendency to analyze and classify individuals, which is seen as antithetical to the belief that "each person has his own individuality, not to be compared to that of anyone else" (7, p. 227).

With the volunteers' training in nondirective interviewing techniques and their values regarding relationships with others, they had difficulty avoiding sadomasochistic entanglements with chronic callers. The volunteers tended to vacillate between overacceptance and rejection; subsequently, frustration and their guilt about their anger pushed many of the most sensitive and enthusiastic staff members to the verge of quitting their hotline work. In such situations we feel that professional supervision can be useful in counteracting the emotional exhaustion or burned-out feeling described by volunteers.

During in-service training sessions, both in small and large groups, volunteers initially asked general questions about mental illness, suicide, and community resources. But then, rather quickly, someone exploded with a plea—or challenge—for information about how to handle a particular repeater known to virtually every volunteer.

We found it most effective to talk about such callers in terms of why they might be repeaters. The young, supposedly black caller was discussed as someone who probably had a lifelong pattern of searching for understanding and acceptance, but also a need to feel anger about his inability to obtain what

he sought and a fear of the closeness that he wanted. He asked for total acceptance—which the volunteers were usually only too ready to try to give him—but also acted out the angry and frightened components and provoked rejection. As the group members discussed their experiences with him, they became convinced that he repeatedly played out this drama in his relationships with volunteers.

As they began to give up the fantasy that at some point their total acceptance would be helpful, they were able to deal more honestly with their anger at having been used in a way that was neither therapeutic to the caller nor gratifying to them. Here the supervisors could provide the information that anger and frustration do not necessarily mean failure, but can be used as data in understanding a caller's pattern of relating to others.

The volunteers seemed to be able to use the supervisors' permission and encouragement to analyze in the service of developing a more constructive approach to callers. Once staff members realized that structuring some calls

had a use in their work and that their own feelings could be experienced fully rather than suppressed, they began to apply this knowledge to their interaction with other repeaters. With their new understanding of the patterns of relationships, they began to be able to place reasonable limits on the length and content of contacts with the more difficult callers.

REFERENCES

1. Beitler K (ed): Exchange. Minneapolis, Youth Emergency Service, April 1971
2. Lindemann E: Preventive intervention in situational crises, in Proceedings of the XIV International Congress of Applied Psychology. Edited by Nielsen GS. Copenhagen, Munksgaard, 1962, pp 69-87
3. Caplan G: An Approach to Community Mental Health. New York, Grune & Stratton, 1961
4. Farberow NL, Shneidman ES, Litman RE, et al: Suicide prevention around the clock. *Amer J Orthopsychiat* 36:551-558, 1966
5. Farberow NL: Ten years of suicide prevention—past and future. *Bulletin of Suicidology* 6:6-11, 1970
6. Pretzel PW: The volunteer clinical worker at the suicide prevention center. *Bulletin of Suicidology* 6:29-34, 1970
7. Reich CA: The Greening of America. New York, Random House, 1971

EDITOR'S NOTEBOOK

Crisis Intervention

THE TERM "crisis intervention" is now very popular, but ten years ago it was not even listed in the *Psychiatric Dictionary*. It first appeared in the 1970 edition (1). Those who use the term "crisis" are generally talking about a disruption of adaptation in which the usual problem-solving techniques don't work. This acute upset presents an opportunity for growth when the crisis can be mastered, but in the susceptible individual it may precipitate a regression and the onset of acute psychiatric illness. The fact that it deserves a Special Section in this issue of *The American Journal of Psychiatry* is further evidence of current interest and timeliness.

Crisis intervention is a popular concept because the results are rapid and improvement is common and because of the assumption that anyone can learn to do crisis intervention. However, that assumption is not substantiated by systematic research or a comparison of the results of treatment with other approaches. The techniques of crisis intervention include a variety of approaches. The five papers in the Special Section of this issue discuss emergency services, hotlines, the prevention of hospitalization, and the effect of a crisis on the family. To some, crisis intervention includes a brief stay in the emergency room or brief treatment on an inpatient service. Those treated may be individual patients or whole families.

In line with today's emphasis on making mental health services available to all, crisis intervention is often seen as an inexpensive panacea or as a substitute for a truly comprehensive array of mental health services. Actually most communities have networks of crisis services, and those run by mental health professionals improve their effectiveness when they are coordinated with other human service agencies. Both the Schwartz-Weiss-Miner and the Torop and Torop papers in this issue raise questions about the coordination of such services. The success of crisis services when hotlines are manned by volunteers will depend on the effective use of professional consultation. But Torop and Torop point out how frequently the hotline volunteer is antiprofessional. Such an attitude underscores the question of who can do crisis intervention and of the potential dangers to patients when the unskilled volunteer is responding to his own intuition and bias rather than to a tested set of principles that depend on knowledge of normal human responses and psychopathology. It is encouraging to read

In this section the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

about progress when professional supervision is skillful, but the initial reactions of the Alexandria group give the psychiatrist cause for concern about telephone crisis services.

Another basic problem in the field is to define who the patient is. The traditional category of the individual patient is one with which we psychiatrists are most at ease. Yet the clinical experience of Rubenstein and of Galdston and Hughes suggests that crisis intervention is most useful when the family is the patient. Clinical criteria have not yet been established to determine when it is most helpful to see the family together and when to work primarily with the "patient."

The entire field of crisis intervention will open new vistas in understanding normal ego functions when we can study the factors that predict successful or unsuccessful coping in problem solving. Although the technique of crisis work is to focus on the present, a great deal would be discovered if additional attention were paid to the individual's susceptibility to crisis and to the reaction of families to crisis. Much more needs to be done to define the goals and objectives of crisis intervention techniques. In a field where response is rapid and change is expected, it is too easy to slide over the process and to avoid deeper inquiry. Description of crisis reactions remains unsystematized; the challenge of classifying such reactions should interest more investigators.

Outcome studies that include follow-up are especially desirable. The Decker-Stubblebine study reports on the follow-up of individual crisis cases treated with brief hospitalization. The Langsley-Kaplan group (2) reported on follow-up after outpatient family crisis therapy with families and compared results with those found where similar patients were treated by hospitalization. Follow-up studies of individual outpatient crisis intervention, of the outcome of persons served by hotlines, or of the effectiveness of home visits contrasted with services in professional settings are lacking. Many of us claim that effective crisis intervention does not deter motivated patients from therapy for chronic problems, but do we really know that? The claims and counter claims of the professional and nonprofessional volunteer groups have not been subjected to test.

Finally, we should hope for more than symptomatic relief. It is clear that crisis intervention can alleviate immediate distress and can avoid regression and hospitalization, but can crisis intervention teach more effective coping in the future? Without seeking that goal, we fly in the face of Caplan's original definition of crisis as opportunity for growth as well as signal of danger.

Despite all that is unknown about crisis intervention, the fact remains that new treatment techniques have made it possible to intervene in a process that would otherwise surely lead to regression and chronicity. For many community mental health programs, crisis intervention services have been given first priority. Families and individuals have been helped over a series of developmental and accidental problems. Unnecessary hospitalization has frequently been averted by crisis intervention. If the next decade sees as much progress as the past, some of the questions of this editorial may be answered, and many troubled people will be helped through dangerous waters.

REFERENCES

1. Hinsie LE, Campbell RJ: *Psychiatric Dictionary*, 4th ed. New York, Oxford University Press, 1970, p 606
2. Langsley DG, Machotka P, Flomenhaft K: Avoiding mental hospital admission: a follow-up study. *Amer J Psychiat* 127:1391-1394, 1971

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Changes in the Offing

OURS IS SAID to be an era of the most rapid changes known to man, and it is said also that change, while inevitable, is sometimes painful. It is not surprising, therefore, that change has caught up with our journal—free of pain, we hope, but change nevertheless. All of this has to do with the fact that the January 1973 issue of *The American Journal of Psychiatry* will appear in a new size and format and that for the first time a new volume will start with the January issue. Our readers have already been warned of the latter change—that in order to make each volume cover a calendar year volume 129 would include only six issues and volume 130 would begin with the first month of 1973.

Why the change in format? Well, technology has caught up with us. A number of medical journals have already gone to "A" size (8¼ by 11 inches), including *Archives of General Psychiatry* and our sister publication, *Hospital and Community Psychiatry*, and it is expected that many other professional journals will soon follow suit. Our researches indicate that the printing technology for periodicals is moving steadily in the direction of standardization at the "A" size. Our printer, Dartmouth Printing Company, advises us that their new high-speed four-color press will accommodate the "A" size more efficiently than our present "B" size. Also, we hope that our new cover design will help to hold the color there to a more consistent shade of green.

It is noteworthy, too, that the *Journal* has lost advertising because the advertisers' plates are more frequently made up in the "A" size than in other sizes. With the rise in printing costs and postage, advertising revenue becomes more important to us. (APA members have already been informed that our acceptance of advertising is governed by a set of carefully worked-out rules.)

Change to the new size with the advent of the new volume in January has stimulated us to also make some desirable changes in typography and page layout. And with a larger page we will be a little better equipped to handle the veritable flood of manuscripts that regularly inundates the *Journal* office.

The Editorial Board and the staff regret any inconvenience that these

changes might engender; we recognize, for example, that the symmetry of bound volumes will be disturbed. But we hope all will recognize that we are in the grip of technological and stylistic changes, and we also hope that after some initial discomfort, we will all be proud of our new format.

F. J. B.

BRIEF COMMUNICATIONS

Aberrant Response to Diazepam: A New Syndrome

BY LT. CDR. RICHARD C. W. HALL, MC, USN, AND JOY R. JOFFE, M.D.

The authors report on six patients with diazepam (Valium) toxicity. All showed symptoms of tremulousness, apprehension, insomnia, depression, and (later) ego-alien suicidal ideation. None had a history of previous psychiatric disorder, and all were taking greater than the maximum recommended dose of diazepam. Because the quality of the suicidal ideation in this syndrome differs from the usual indicators of suicidal intent, physicians should be alert to early symptoms of the syndrome and take measures to protect the patient against suicidal impulses.

SINCE ITS introduction in 1963, diazepam (Valium) has received widespread interest because of its efficacy in practically every major field of medicine. The literature contains many references to its safety and to its lack of toxic effects at higher than usual doses.

In recent years, Rao (1), Gundlach and associates (2), McDowall and associates (3), and Ryan and associates (4) have called attention to increased depression and suicidal thoughts and tendencies in patients on diazepam. Holbrook (5), in reporting a variety of

side effects of 200 patients in a medical practice, noted increased sensitivity and prolonged effects of the medication in the elderly. Hallberg and associates (6) and Daily and Kane (7) reported acute toxic psychoses associated with diazepam, and Barten (8) reported similar manifestations when diazepam was withdrawn.

The current prospective study was begun after one of us (R.C.W.H.) saw two patients who were remarkably similar in a busy emergency room. Both patients appeared carrying a bottle of diazepam; they were complaining of spontaneous weeping, confusion, decreased memory, and a "drive to suicide." Both had been taking more than 40 mg. of diazepam every day for about the same period of time (six and eight days, respectively). Both had concomitant vascular disease, and both improved markedly within one week after discontinuing diazepam. They related the onset of their symptoms to the onset of diazepam therapy. The question of a toxic syndrome was suggested by the pronounced clustering of specific symptoms considered by the patients to be dystonic, implusive, and temporally associated with the onset of diazepam therapy. This question led to the prospective study reported here.

Method

All patients who appeared in the emergency room of the Johns Hopkins Hospital with complaints of depression, suicidal idea-

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This section includes articles that are usually, although not always, less lengthy than the preceding articles. Included are clinical notes, case reports, historical notes, and other material selected by the Editor. In general, articles submitted for this section should be no longer than eight double-spaced typed pages.

tion, or confusional states associated with the commencement of diazepam therapy within the preceding 30 days and who were receiving no other psychotropic medications were personally seen by one of us (R.C.W.H.). Patients receiving other psychotropic medications either alone or in combination with diazepam or who had taken the drug regularly for longer than 30 days were excluded from the study.

When the patients were seen, a complete medical, psychiatric, social, and drug history was taken. Family members were interviewed. Private physicians were contacted regarding the dosage of diazepam prescribed and when therapy with the drug was begun. They were also asked to assess the patient's previous emotional stability and the presence of any target symptoms before diazepam was taken. Following immediate treatment, the patients were followed daily for one week and then at one-month, six-month, and one-year intervals. At each follow-up visit, a complete psychiatric interview and examination was performed, and the family was interviewed when possible to validate the patient's report. Data on symptoms were obtained by using a symptom checklist and by interview. The assessment of personality types was made by using the definitions provided in the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (9).

Results

Ten patients met the initial criteria of the study, but only six could be followed for one year. All six patients showed a cluster of symptoms consisting of tremulousness, apprehension, insomnia, depression, and suicidal ideation of an ego-alien type (for example, "I feel as if I'm going to kill myself, but I don't really want to die. I don't understand why I feel this way"). None of the items in this symptom cluster was present in any patient prior to therapy with diazepam. All of the other cluster symptoms appeared before the onset of suicidal ideation. Within seven days after diazepam was discontinued all of the cluster symptoms subsided and did not reappear during the observation period.

The following case reports illustrate pertinent medical and psychiatric data for each of the patients.

Case Reports

Case 1. This patient, a 73-year-old widow with a high school education, had no history of previous psychiatric disorder. She was living alone and was lonely and fearful of her increasing disability. Two years previously she had had an adverse drug reaction to secobarbital (Seconal), which was manifested by agitation and confusion. Her past medical illnesses included arteriosclerotic cardiovascular disease, peptic ulcer, chronic pyelonephritis, and renal calculi. She was currently taking 60 mg. of diazepam every day, multivitamins, Maalox, and 500 mg. of chlorothiazide (Diuril) every day. The patient identified diazepam, which she started taking four days prior to admission, as the cause of her mental state. When seen, she manifested muscular weakness, tremulousness, apprehension, nightmares, insomnia, spontaneous weeping, confusion that increased nocturnally, memory deficit, impairment of concentration, and ego-alien suicidal ideation. All symptoms cleared six days after diazepam was discontinued. The target symptoms did not recur during the one-year follow-up period.

Case 2. This patient, a 24-year-old divorced woman who was a high school graduate, was living alone. She had developed glomerulonephritis at age 16. She had been taking 40 to 60 mg. of diazepam daily for eight days prior to admission; it was prescribed because the patient was "nervous after fight with boyfriend." There was no history of previous psychiatric symptomatology or previous adverse drug reaction, and the patient was taking no other medication. She appeared with tremulousness, spontaneous weeping, apprehension, insomnia, decreased concentration, memory deficit, and ego-alien suicidal ideation. She identified diazepam as the cause of her condition. All symptoms cleared by the fourth day following discontinuation of the drug, and none recurred during the one-year follow-up period.

Case 3. This patient was a 35-year-old married woman who was a high school graduate and who was living with her family. She was described as having an obsessive-compulsive personality and was under considerable stress because her six-year-old child with congenital heart disease was being evaluated for open heart surgery. Six weeks prior to admission, the patient had been in cardiac decompensation secondary to essential hypertension. Her medical history was otherwise negative except for a urticarial reaction to penicillin. Her current medications were 60 mg. of diazepam every day, 50 mg. of hydrochlorothiazide (Hydrodiuril) every day, and .25 mg. of digoxin every day. The patient believed that diazepam, started ten days prior to her admission for hypertension, chest pain, and palpitation, was responsible for her current mental

state. On admission she had muscular weakness, tremulousness, insomnia, apprehension, spontaneous weeping, nightmares, deficit in concentration, feelings of worthlessness, and ego-alien suicidal ideation. Her symptoms cleared one day after the diazepam was discontinued, and none of the target symptoms reappeared during the one-year follow-up period.

Case 4. This patient was a 20-year-old single woman with a partial college education. She had no history of previous psychiatric disorder and did not report recent situational stress. She was currently living alone. She was started on diazepam 12 days before admission as a substitute for diphenylhydantoin (Dilantin) and phenobarbital, prescribed for a postmeningitic convulsive disorder that had been well controlled for seven years. She had a history of adverse drug reaction to triptelennamine (Pyribenzamine) that consisted of excitation, disturbed coordination, and inability to concentrate. She was currently taking 100 mg. of diphenylhydantoin (Dilantin) three times a day, 30 mg. of phenobarbital three times a day, and 40 mg. of diazepam every day. The patient identified diazepam as the cause of her symptomatology, which consisted of tremulousness, insomnia, apprehension, depression, and ego-alien suicidal ideation. Two days following the discontinuation of diazepam, all target symptoms disappeared, and there was no recurrence during the year of observation.

Case 5. This patient was a 45-year-old married woman with a tenth-grade education who was living with her family. She was described as obsessive-compulsive. She had no history of recent situational stress, previous psychiatric disorder, or adverse drug reaction. Her medical history included hyperthyroidism and diabetes mellitus, for which she was daily taking 100 mg. of propylthiouracil, 5 mg. of methimazole, 30 units of insulin, and 60 mg. of diazepam. The patient identified the diazepam, which she started taking ten days prior to admission to diminish her nervousness, as the cause of her current mental state. On admission, she had muscular weakness, tremulousness, nightmares, insomnia, spontaneous weeping, impairment of concentration, depersonalization, depression, and ego-alien suicidal ideation. Her symptoms cleared two days after discontinuing the diazepam, with no recurrence during the one-year observation period.

Case 6. This patient was a 69-year-old married woman who had an eighth-grade education and who was living with her family. She was described as having a cyclothymic personality and had seen a psychiatrist for four months after a myocardial infarction, which she had had 14 months previously. She had no history of adverse drug reaction. Medi-

cal history revealed arteriosclerotic cardiovascular disease, myocardial infarction, and diabetes controlled by diet. On admission she was taking 1 mg. of digitoxin daily, 500 mg. of chlorothiazide (Diuril) daily, and 40 mg. of diazepam daily. The diazepam had been prescribed six days previously "to help the patient relax." The patient had muscular weakness, parasthesias, insomnia, confusion with nocturnal intensification, tremulousness, spontaneous crying, "grief in spells," apprehension, depression, and ego-alien suicidal ideation. All symptoms cleared by the seventh day after diazepam was discontinued and did not recur during the one-year follow-up period. This patient, like the other five, identified diazepam as the agent causing her symptomatology.

The tremulousness seen in all six patients manifested itself as a fine tremor involving the upper extremities. One patient manifested a facial tic, four complained of muscular weakness, and one experienced pronounced parasthesias of the hands and legs. When diazepam was withdrawn, all symptoms cleared.

The apprehension was acute in onset, being intense and thematically centered on the patients' fear of becoming insane. All of the patients related the apprehension to perceived changes in their cognitive processes and bodily perception.

The insomnia was manifested as an inability to achieve sleep due to ruminations having a confused but compulsive character. Three patients experienced harrowing and unusually vivid nightmares that further militated against sleep, and two patients reported severe nocturnal confusion. Perseverative thoughts, which interfered with the onset of sleep, were also present, although less influential, during the daylight hours.

The depression in this syndrome was sudden in onset in previously stable individuals (five out of six) who were unable to isolate causative factors for it. Its onset followed the institution of diazepam therapy (primarily for medical reasons) by four to 12 days. The depressive symptomatology subsided dramatically within from one to seven days after diazepam was discontinued. The depression was characterized by marked apprehension but was qualitatively different from that of classical agitated depression. It should be noted that four of the six patients evidenced an impairment in concentration, and three of the six reported feelings of both uselessness

and worthlessness. Five of the patients reported spontaneous crying without apparent cause.

The suicidal ideation present in all of these patients was the last symptom to develop and was striking in that it was of an ego-alien type and was acute in onset. Patients felt "driven" as if by some "outside force" to commit suicide without the concomitant wish to die.

Discussion

Patients showing an increase in suicidal thoughts and tendencies associated with diazepam therapy have been previously described. The six cases reported here confirm these earlier findings and in addition suggest a specific syndrome associated with increased suicidal tendencies of an ego-alien type. The sudden appearance of ego-alien suicidal ideation may explain the fact that some of the patients described in the literature (4, 8) were not recognized as suicidal. This symptom, by virtue of its sudden appearance and its ego-alien quality, suggests the extreme hazard of continuing diazepam therapy in patients who show toxic side effects from the drug, since the usual indicators of suicidal intent are not present. The suicide potential is further enhanced by the drug-induced confusion that diminishes normal coping response.

Two of the six patients were over 65 years of age and evidenced a comparatively more rapid onset of toxicity—an average of five days, as compared with ten days in the group under 65 and a prolonged clearing of a six-and-one-half-day average as compared with two-and-a-half-day average for the younger group. This may be demonstrative of the increased sensitivity of the elderly to diazepam-like drugs or of the lack of consideration given in these two cases to the fact that the recommended dosage for the elderly is considerably below that for the general population. It should further be noted that the two elderly patients exhibited a greater degree of confusion and marked nocturnal intensification.

Significant vascular disease was present in all of the patients except for case 4, who had a postmeningitic convulsive disorder. In the group under 65 years of age, the patient with glomerulonephritis (case 2) had a slightly shorter period of onset for symptoms and re-

quired two and one-half times longer for the symptoms to subside.

The half-life of diazepam in the blood has been shown to be seven to ten hours, followed by a slow component (consisting of diazepam and its N-demethylated metabolite) with a half-life of three days (10). Seventy percent of a dose of H³-labeled diazepam appears in the urine. Diazepam has an excretion rate half-life of three days (11) and is excreted into the urine as a glucuronide, suggesting hepatic metabolism of the drug prior to renal clearance. It is reasonable to assume that in the face of peripheral vascular disease and/or renal impairment there will be delayed excretion of the drug, causing a prolongation of the time for symptom clearance. The data obtained from the onset of therapy to the development of symptoms and from the time the drug was discontinued until the symptoms cleared support this hypothesis.

Conclusions

Six patients with a demonstrated aberrant response to diazepam showed a cluster of symptoms consisting of tremulousness, apprehension, insomnia, and depression, followed by ego-alien suicidal ideation. In this series, the syndrome was abrupt in onset and marked in severity and appeared in individuals who had been previously emotionally stable. All of the patients had been taking greater than maximally recommended doses of diazepam (i.e., greater than 40 mg. every day), primarily for medical conditions.

The significance of this syndrome lies in the quality of the suicidal ideation, which negates the usual indicators of suicidal intent. The appearance of any of the preliminary symptoms of this syndrome is therefore an immediate indication for the withdrawal of diazepam and the protection of the patient against suicidal impulses. Furthermore, it is strongly suggested that physicians adhere to the maximum recommended dosages and be aware of the possibility that peripheral vascular disease and age may be a factor in the appearance of cumulative toxic effects.

REFERENCES

1. Rao AV: A controlled trial with "Valium" in obsessive compulsive state. *J Indian Med Ass* 42:564-567, 1964

2. Gundlach R, Engelhardt DM, Hankoff L: A double-blind outpatient study of diazepam (Valium) and placebo. *Psychopharmacologia* 9:81-92, 1966
3. McDowall A, Owen S, Robin AA: A controlled comparison of diazepam and amylobarbitone in anxiety states. *Brit J Psychiat* 112:629-631, 1966
4. Ryan HF, Merrill BF, Scott GE, et al: Increase in suicidal thoughts and tendencies associated with diazepam therapy. *JAMA* 203:1137-1139, 1968
5. Holbrook AA: Experience with diazepam in internal medicine. *Med Times* 94:423-433, 1966
6. Hallberg RJ, Lesser K, Kane TJ: Korsakoff-like psychosis associated with benzodiazepine overdose. *Amer J Psychiat* 121:188-189, 1964
7. Daily RJ, Kane FJ: Two severe reactions to benzodiazepine compounds. *Amer J Psychiat* 122:577-578, 1965
8. Barten HH: Toxic psychosis with transient dysmnesic syndrome following withdrawal from Valium. *Amer J Psychiat* 121:1210-1211, 1965
9. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 2nd ed. Washington, DC, APA, 1968
10. Spark H, Coloman AS: Diazepam intoxication in a child. *Amer J Dis Child* 190:128-129, 1965
11. Schwartz MA, Koechlin BA, Krol G: Metabolism of diazepam in rat, dog, and man. *Fed Proc* 22:367-372, 1963

The Importance of Psychiatrists' Telling Patients the Truth

BY WILLIAM S. APPLETON, M.D.

Although psychiatrists advocate that physicians be honest with their patients, they themselves frequently withhold information from their patients. Their fear may stem from uncertainty about various aspects of an illness or a desire not to alienate the patient. The author believes that being informed helps the patient find solutions to his problems and results in more effective therapy.

A FORMER PROFESSOR of medicine at a leading university is said to have expelled a third-year student from the wards, the school, and medicine in front of 50 colleagues during grand rounds. The student's offense? He told a patient he had cancer.

As the student, frightened and near tears, was about to go, the professor called him back and said: "Now you have a small idea of what it is like to be told you have cancer."

I have always thought, as did many of the students who repeated it, that this story meant the professor did not believe in telling patients they were going to die. Looking back, it seems equally plausible that he wanted his students to understand the emo-

tional impact of such a pronouncement on the patient.

To summarize current medical opinion on the matter: Tell the patient the truth about whether or not he has a fatal illness if he really wants to know. (There is extensive discussion in the medical and psychiatric literature about how to tell which patients really do want to know, how the patient will react once informed, and how to identify those patients who should be protected from the truth about fatal illnesses.)

The Spirit of Diagnosis

Psychiatrists have frequently criticized internists and surgeons for indulging in charades that not only do not fool the fatally ill patient but also confuse and disorient him. My colleagues often admonish physicians and surgeons to "communicate," to tell the patient the truth more often.

The irony of the psychiatrist's position in all this becomes overwhelmingly apparent as one examines the same problem in the field of mental illness. In the teaching hospital in which I work, in the many institutions I have visited, and in the hospitals where I have trained, too often psychiatric patients were told nothing about their illness.

The psychiatrist usually reasons that schizophrenia and depression are not predictable diseases with known causes. Therefore,

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to tell a patient he or she is so afflicted would have no therapeutic or prognostic meaning. He correctly believes the spirit of diagnosis to be not one of mere labeling but rather one of suggesting causation, therapeutic action, and outcome. Ironically, the internist or surgeon often employs similar reasoning to conceal the diagnosis of cancer: Why needlessly upset the patient when the disease may never recur or may be hopelessly malignant?

In most cases the patient, and perhaps his family, should be told what the psychiatrist concludes. If the diagnostic term is imperfect, it must be explained to the extent of the psychiatrist's knowledge; for example, "The schizophrenia is such that a relapse may occur within two years and the following symptoms should be watched for." The psychiatrist should do his best to warn the patient that "when you are stressed emotionally you have a tendency to confuse what is in your mind with what is real. Therefore, if a loved one were to die or if you were to move across country, you might be in danger of relapse." Perhaps out of an unwillingness to deemphasize the uniqueness of the individual and to view him statistically, psychiatrists collect little practical data of this kind. Surgeons know, for example, that if such and such a cancer has reached the lymph nodes or liver, the prognosis, on the average, is a certain number of months, which can be increased by a certain number of methods. Psychiatrists in American universities, however, do not tend to think that the schizophrenia of a 19-year-old with a good premorbid personality has "X" number of chances of recurring in five years, ten years, or never, and is subject to influence by "Y" number of means.

Psychiatrists have such strong feelings against supplying a diagnosis that they sometimes utter it out of despair. "You are borderline and will never be well," one analyst told his patient after three or four years of analysis. He thus avoided his medical obligation to cure her and at the same time released some of his frustration at being unable to do so.

The Psychiatric Model

Another reason for withholding the diagnosis arises from the mistaken application of the psychiatric model, as opposed to the medical model. In the psychiatric model, the doc-

tor allies himself with the healthy part of the patient's personality to observe and understand the causes of what both agree to be undesirable behavior or emotion. It is then up to the patient to change himself in the context of the psychiatric relationship. The medical patient submits his illness for diagnosis and is either told what to do or lets the doctor do something therapeutic to him.

Organically (biologically) oriented psychiatrists use the medical model. For example, they might say to a patient: "You have a depression with the following symptoms. Here is how to recognize it early and what to do about it." The analytic psychiatrist, predominant in the United States and especially in university centers, uses the psychiatric model and believes depression to be a "stance" to coerce help or love from a significant person. He does not regard his patient as having a depressive illness but regards him as not having abandoned the childlike expectation of being "given to" as opposed to the adult role of achieving for oneself. Even if this model is correct and if (as Thomas Szasz has stated) mental illness is a myth rather than a disease, schizophrenia does not exist, depression is a stance rather than a biochemical condition, and borderline means immaturity, I believe psychiatrists should nonetheless be sure to give the diagnosis, albeit in these "mythical" terms.

The word "diagnosis" means to distinguish or to know and refers in medicine to recognizing a disease from its symptoms. More than a mere label, it is the conclusion reached about causation from which therapeutic action is taken. The psychiatrist must tell the patient the result of his thinking. If he believes the patient's problems stem from misinterpretations of reality or from an unwillingness to put off the moment's pleasure for future reward, he ought to say so. If the physician believes that the patient is waiting in a depressed stance for others to take care of him, he should tell him. Being informed of his diagnosis helps the patient achieve the solution he desires; the doctor's thinking is also channeled more precisely. Once the diagnosis is stated, the patient may act immediately or, when he delays or forgets, his psychiatrist may remind him of it. In addition, a precise statement of the illness or problem helps the practitioner assess its outcome more accurately.

Fear of Reinforcement

If full disclosure is such a good idea, then why do psychiatrists so often fail to give their patients the diagnosis? One reason is the psychiatrist's reluctance to repeat what angry families have been telling the patient for months or even years. "You want to be waited on. You won't take responsibility." Some psychiatrists are so troubled by members of their own families that they fear venting their anger and frustration on their patients and, as a result, go to the opposite extreme and say nothing at all. Others restrict themselves to obscure language for fear of producing the same reaction the patient has toward members of his family whom he either dislikes or mistrusts. If such reluctance represents true relationship-building attempts by the psychiatrist, it can be defended. For example, telling a paranoid that he is projecting (i.e., that his beliefs are unreal) is unwise if it alienates the therapist from the person he is trying to help. But if the psychiatrist's silence is due to fear of the patient's anger and results in avoiding transference reactions, it then defeats the whole purpose of the analytic therapist, which amounts to the analysis of the transference reaction itself. A fact frequently forgotten is that the patient will often listen to the trained and neutral physician when he will not listen to his wife or mother. Just because a patient's mother said something does not mean that it is necessarily wrong.

"But he won't listen," many of my colleagues would reply. Tell the patient what you think first, and if he does not listen, you can go on from there. Some psychiatrists believe that it is bad for the patient to know that he is schizophrenic because he may despair and stop trying. A diagnosis of schizophrenia is certainly depressing, and the patient may go through a stage of hopelessness. So does a newly diagnosed cancer patient. Psychiatrists and many medical doctors believe that most cancer patients know the nature of their illness without being told. Most schizophrenics do too, except for those too far out of contact. Telling a patient what he already knows has the added advantage of making him feel that the doctor is being honest.

The failure of psychiatrists to communicate with their patients has repeatedly come to my attention. In my clinic, psychiatric patients are given elaborate diagnostic exercises, in-

cluding one-hour interviews, but they are often denied a careful review of the physicians' clinical findings. A hospitalized patient recently called this to my attention when, after a conference lasting an hour and a half, she waited outside to ask me what was wrong and what she should do. This frequently happens and is usually followed by the conference chairman's hasty reply, "Ask your own doctor," as he rushes away. I decided that since this 60-year-old woman had patiently answered my questions in front of 35 colleagues, it was only fair to tell her what I thought. I did, and she was grateful and very much relieved.

A psychiatric resident whom I supervise presented the case of a 35-year-old virginal man who had been hospitalized with severe attacks of anxiety. The man repeatedly asked why he had palpitations and whether he was a homosexual. Doubt and fear prevented the doctor from answering these questions. He was uncertain whether the palpitations signaled suppressed aggression, he wanted the patient to develop his independence and a capacity for decision making, and he thought the patient, who liked to argue, would disagree.

Ironically, the resident shared the patient's concerns about himself. The resident believed that the patient's fear of becoming homosexual if he developed freedom of sexual expression was well founded. In spite of the therapist's silence, the patient thought he detected encouragement to ask a young woman for a date. "I didn't know you were interested in girls," the woman had said, refusing him, and the patient vowed never to invite another woman out. To this series of events, the resident showed no reaction. When the patient reported fantasizing a woman while masturbating for the first time in his life, he was greeted with more silence. As soon as the psychiatrist abandoned his uncertainty, took a stand, and openly encouraged his patient, the patient asked the young woman out again; this time she accepted.

A doctor ought not to allow himself to wait for complete certainty before giving his opinion, since this can become an excuse for silence. When a patient fears flying, the psychiatrist cannot guarantee that the plane will arrive safely but should, nonetheless, encourage him to try, especially if the physician has mastered his own fear. Some patients benefit

by being told, "I worry in airplanes too. In fact 90 percent of all passengers are happier when the plane lands." Others require the assurance that the chances that one will die in a plane are less likely than in an automobile.

An important reason why psychiatrists withhold information, then, is doubt about really knowing the answers. The issue is one of epistemology: how do we know what we think we know, and when can we be sure we are right? Doctors are both intellectual and skeptical. They are aware of past medical certainties having turned into foolish relics, e.g., blood-letting, purgatives, and chaining the mentally ill. This leads them to shy away from being definite and risking an opinion that may later prove to be wrong.

But this cautious attitude can be harmful at times. This was manifested by an experiment in which psychiatrists were trained to give mood-elevating drugs to a group of depressed patients in two ways: 1) in a positive manner (this drug will help you and is very effective), and 2) in a scientific manner (this drug may or may not work, but try it and see). The cure

rate for the first group was twice that of the second.

Summary

Psychiatrists advocate honest and open communication by physicians with patients but too often do not practice what they preach. Their reasons for silence include uncertainty about the cause, treatment, and prognosis of psychiatric illnesses and unwillingness to depress, demoralize, anger, or alienate their patients.

If the psychiatrist can overcome his doubts and to the best of his ability honestly explain what is wrong with the patient and what is necessary to overcome the problem, then therapy will become more rapid and effective and its success or failure will be easier to evaluate. Giving the correct diagnosis and prescription may not make the psychiatrist popular with his listener, but this is not important as long as the patient can hear what is said and can learn to make use of it.

Sex, Age, and the Diagnosis of Hysteria (Briquet's Syndrome)

BY SAMUEL B. GUZE, M.D., ROBERT A. WOODRUFF, JR., M.D.,
AND PAULA J. CLAYTON, M.D.

A study of hysteria (Briquet's syndrome) in 500 psychiatric clinic patients showed that men and women differ with regard to the number of symptoms reported and to the distribution of symptoms by age. Young women reported a disproportionately greater number of symptoms than men or older women. The authors conclude that a diagnosis of hysteria, which is based upon a polysymptomatic disorder beginning early in life, is more likely to be made in women than in men.

SINCE HIPPOCRATES, physicians have reported that hysteria is primarily a disorder of women. This has been true even though investigators have approached hysteria in different ways. The results of our studies have

been similar: No more than two or three percent of hysterics have been men. This paper presents certain data in an attempt to explain the striking sex difference.

Our general approach to the diagnosis of hysteria is similar to Briquet's (1). Therefore, to reduce controversy about terminology and to minimize perjorative associations, "Briquet's syndrome" has been proposed as a

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TABLE 1
Frequency Distribution of Symptoms

NUMBER OF SYMPTOMS	MEN	WOMEN
0	6	3
1	6	7
2	9	3
3	9	8
4	10	7
5	15	12
6	9	9
7	9	18
8	15	13
9	11	13
10	16	23
11	13	25
12	11	20
13	3	18
14	7	19
15	6	17
16	5	18
17	6	12
18	4	10
19	6	10
20	1	6
21	1	10
22	1	11
23	2	9
24	1	2
25	1	2
26	0	2
27	0	3
28	1	3
29	0	2
30	0	2
31	1	2
32	1	2
33	0	1
34	0	1
35	0	1

synonym for this disorder (2). The condition has been defined (3) as:

... a polysymptomatic disorder that ... begins early in life ... and is characterized by recurrent or chronic ill health, the complicated history of which is frequently described dramatically. Characteristic features of the clinical history, most of which are to be seen in all patients, include many and varied pains, anxiety symptoms, gastrointestinal disturbances, urinary symptoms, menstrual difficulties, sexual and marital maladjustment, nervousness and mood disturbances, and conversion symptoms. Frequent visits to physicians, ... excessive hospitalization, and excessive surgery parallel the florid symptom picture (3, p. 493).

For research purposes, checklist criteria derived from this definition have been proposed and validated by follow-up and family studies (2, 3). These criteria are based upon nearly 60 symptoms distributed among ten groups (see Appendix 1). A diagnosis of hysteria (Briquet's syndrome) requires a history of at least 25 symptoms in at least nine

groups. These symptoms must be medically unexplained, and ill health must have begun before age 35. A diagnosis of probable hysteria is made if 20 to 24 symptoms are present in nine groups under similar conditions. Since none of the symptoms in group 7 (menstrual symptoms) occur in men and since the sexual symptoms in group 8 are less common among men, it is obviously more difficult to make the diagnosis in a man using these criteria. The other 50 of the 59 symptoms, however, are presumably as likely to occur in a man as in a woman.

Since the diagnosis of hysteria, or Briquet's syndrome as defined here, is made in patients with a polysymptomatic disorder, an analysis of the frequency of these 50 symptoms in men and women, regardless of diagnosis, should help determine the extent to which men exhibit a polysymptomatic syndrome similar to that seen among women.

Method

The subjects, a group of 500 patients from the Washington University Psychiatry Clinic in St. Louis, Mo., were selected to provide a representative sample for clinical, family, and follow-up studies. The standardized interview and the diagnostic criteria have been described elsewhere (2, 4, 5). The distribution of the frequencies with which the diagnostic symptoms were reported were determined and analyzed by the age and sex of the patient.

Results

The results are summarized in figure 1 and

FIGURE 1
Distribution of the Number of
Diagnostic Symptoms by Age

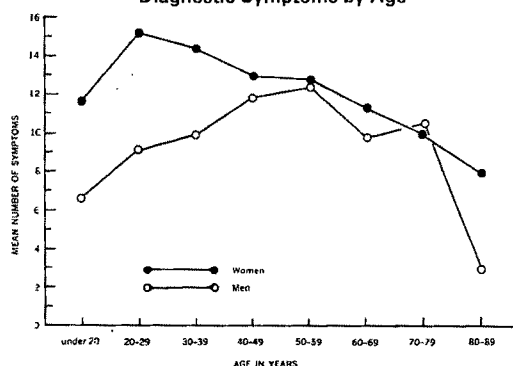


TABLE 2
Age Differences Between Patients in Upper and Lower
Thirds of the Distribution of Number of Symptoms

SEX	NUMBER	MEAN AGE (YEARS)	PERCENTAGE 40 OR OLDER
Men			
Upper third	58	37.2*	39.6*
Lower third	55	30.4	20.0
Women			
Upper third	109	36.1	37.6*
Lower third	116	39.8	51.7

*Difference between upper third and lower third is significant at .05 level.

tables 1 and 2. Table 1 portrays the frequency distribution of the diagnostic symptoms for men and women. The men reported a mean of 9.6 symptoms, and the women a mean of 13.4 symptoms. The difference is significant at the $p < .001$ level.

Figure 1 presents the distribution by age of the number of diagnostic symptoms for men and for women. For the men, there was a gradual increase in the number of symptoms with age, reaching a peak in the 50s and then falling off. For the women, the peak was reached in the 20s, followed by a gradual decline. The difference between the sexes under age 40 was statistically significant ($p < .001$); in those 40 and older, it was not.

Table 2 presents the relationship between age and the number of symptoms for each sex in a different way—by comparing those in the upper third of the distribution of the number of symptoms with those in the lower third. Again a sex difference was noted. The men in the upper third were nearly seven years older than those in the lower third, while the women in the upper third were nearly four years younger than those in the lower third. Put another way, twice as many men in the upper third as in the lower third were 40 years old or older; for the women, the pattern was reversed, with about a third of the women in the upper third and half of the women in the lower third 40 years old or older.

Discussion

In all kinds of studies women have almost invariably been found to report more symptoms than men. Thus the difference in the mean number of symptoms in this study is not surprising. What is noteworthy, however, is that the curves in figure 1 are not parallel. The differences between men and women were not proportional at all ages.

Since items in the research interview concerning diagnostic symptoms refer to lifetime experience, the number of symptoms would be expected to increase with age. Among male patients, this was generally the case, but the women were different. Younger women reported a greater number of symptoms than did older women. In other words, among psychiatric patients, young women are more likely to report a disproportionately great number of symptoms than are young men. Thus, the diagnosis of hysteria, when based upon a polysymptomatic syndrome beginning early in life, is much more likely to be made in women. As yet unanswered, but requiring further research, is the question whether the diagnosis refers simply to the most extreme form of this tendency or whether it identifies a qualitatively different disorder.

REFERENCES

1. Briquet P: *Traité Clinique et Thérapeutique à l'Hystérie*. Paris, J.B. Ballière, 1859
2. Guze SB: The role of follow-up studies: their contribution to diagnostic classification as applied to hysteria. *Seminars in Psychiatry* 2:392-402, 1970
3. Guze SB: The diagnosis of hysteria: what are we trying to do? *Amer J Psychiat* 124:491-498, 1967
4. Guze SB, Wolfgram ED, McKinney JK, et al: Psychiatric illness in the families of convicted criminals: a study of 519 first-degree relatives. *Dis Nerv Syst* 28:651-659, 1967
5. Guze SB, Goodwin DW, Crane JB: Criminality and psychiatric disorders. *Arch Gen Psychiat* 20:583-591, 1969

APPENDIX 1 Criteria for Hysteria

Group 1
Headaches
Sickly

Group 2
Blindness
Paralysis

Anesthesia
 Aphonia
 Fits or convulsions
 Unconsciousness
 Amnesia
 Deafness
 Hallucinations
 Urinary retention
 Trouble walking
 Other conversion symptoms

Group 3

Fatigue
 Lump in throat
 Fainting spells
 Visual blurring
 Weakness
 Dysuria

Group 4

Breathing difficulty
 Palpitation
 Anxiety attacks
 Chest pain
 Dizziness

Group 5

Anorexia
 Weight loss
 Marked fluctuations in weight
 Nausea
 Abdominal bloating
 Food intolerances
 Diarrhea
 Constipation

Group 6

Abdominal pain

Vomiting

Group 7

Dysmenorrhea
 Menstrual irregularity
 Amenorrhea
 Excessive bleeding

Group 8

Sexual indifference
 Frigidity
 Dyspareunia
 Other sexual difficulties
 Vomiting during nine months of pregnancy or hospitalized for hyperemesis gravidarum

Group 9

Back pain
 Joint pain
 Extremity pain
 Burning pains of the sexual organs, mouth, or rectum
 Other bodily pains

Group 10

Nervousness
 Fears
 Depressed feelings
 Need to quit working or inability to carry on regular duties because of feeling sick
 Crying easily
 Feeling life was hopeless
 Thinking a good deal about dying
 Wanting to die
 Thinking of suicide
 Suicide attempts

Psychotherapy by Counter-Manipulation

BY JAMES M. KRAININ, M.D.

Manipulation of the therapist by the patient can sometimes be effectively handled by the therapist's counter-manipulating. The author presents three case reports of patients who manifested behavior that was pathologic but that was perhaps the best immediate solution to altering the patients' current situation. In two cases, the therapist's counter-manipulations were therapeutic; in the third, the therapist acted to validate the patient's pathology with antitherapeutic results.

THERE ARE certain situations in which psychotherapists cannot function adequately by merely listening and talking to the patient. It is almost a cliché that psychotherapy is impossible in a military setting. When I first came on active duty as a psychiatrist in the Air Force, it appeared that one might hope to treat dependents, but that the transient status of most of the personnel on my base, the lack of privileged communication in the military, and the preponderance of referrals for the purpose of clear-cut manipulation virtually precluded psychotherapy with men on active duty.

I found that these considerations do usually preclude long-term analytically oriented psychotherapy. However, I believe that psychotherapy is any interaction in which a designated therapist demonstrates to his patient the self-defeating aspects of the patient's behavior and encourages him to find alternative modes of behavior that will in some way be better for him:

Whenever one individual engaged in an inter-

personal relationship with another functions in such a way as to increase the integrative adaptive capacity of the latter, psychotherapy has taken place. [Therefore psychotherapy is] . . . an interpersonal operation in which the total . . . adaptation of one individual is catalyzed by another individual in such a way that the patient's level of adaptive capacity is increased (1, p. 13).

Sometimes to perform therapy the therapist must manipulate the patient in order to push for change. This is especially true when the therapist is the object of manipulation by the patient. The majority of military personnel I have seen came for treatment because they wished to get out of the service, because they wanted a new assignment, or because their commander wanted clearance for some administrative action against them. Observation has led me to believe that many such men have a history of failure and view themselves as failures. To simply dismiss them from the service adds another failure to their life histories, cementing their image of themselves and diminishing their chances for success on any level.

I have seen many cases turn into games between the psychiatric department and the airman to see whether the psychiatrist can convince the airman that no discharge is possible or whether the airman can convince his doctor that to attempt to keep him in the service is more trouble than it is worth. Thus the military psychiatrist and the patient manipulate each other. The patient's desires may be to his long-term good, but, on the other hand, they may be to his detriment.

Case Reports

I will present several cases in which the issues are made particularly clear by the fact that the patients were not only in the Air Force but also in jail. In each case the subject manifested behavior that was pathologic but that could be considered his best available alternative for bettering his immediate condi-

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tion. To reward such behavior would be to encourage the individual to pursue an approach to life that, in the long run, would be self-defeating.

Therapeutic Counter-Manipulations

Case 1. P. was an airman who appeared in the emergency room with pseudo-seizures. When I first saw him, I thought he was having true convulsions. He did not respond to painful stimuli. He was thrashing about under restraints. However, he was not incontinent. After quite a few minutes of observation, it became apparent that he was responding to grosser changes in his sensory field. He did not respond to 10 mg. of diazepam (Valium), administered intravenously. I admitted him to the psychiatric service. By morning he had ceased his thrashing and had settled into a state of refusal or inability to talk. Eventually I learned that he had been convicted of theft and was to have been sent that day to another base for punishment and rehabilitation.

His hospital stay was prolonged to several weeks' duration because of the development of numerous symptoms such as abdominal pain. Eventually I discharged him to confinement. The same night he returned to the emergency room with the original picture of pseudo-seizures. I was unable to convince the doctor on duty that it was safe to return him to jail. On the ward the following day, I told the patient that while he could probably get himself admitted to the hospital through the emergency room every night, I would merely send him back to jail the following day and that I could play the game longer than he could. P. started arguing that he had not committed the crime for which he had been convicted. I told him that I could not judge him on that score, that he had already been judged, and that he had no alternative but to serve his sentence. He returned to jail and caused no further problems, at least for as long as he was at the base.

Case 2. C. was a young man who was referred to the clinic for evaluation while under investigation for unspecified charges. He was circumstantial and showed considerable inappropriate smiling, and we felt it necessary to schedule psychological testing. Before this could be obtained, however, C. was taken into custody. The next day he was brought to the emergency room. He presented a paranoid picture with feelings of persecution that transcended the reality of the situation. He had been charged with possession of marijuana and of a weapon. This violated his parole, of which he had neglected to inform us.

Since C. was agitated and psychotic, he was admitted. The main issue during his hospitalization was his fear of jail. He was treated with small amounts of phenothiazines. When he became

stabilized, although he still showed some paranoid signs he was returned to jail. His parting words were: "Well, I like it in jail better than in this place, anyhow." His subsequent stay in jail was uneventful, and he has not found it necessary to obtain further psychiatric treatment.

An Antitherapeutic Manipulation

I will present, in contrast, a third case—a man who was clearly mentally ill but whose illness was acknowledged in a definitely antitherapeutic way.

Case 3. D. was a young airman who, while visiting a neighboring town when he was off duty, acted under the delusion that cars were coming to attack the air base and threw rocks and debris on the highway to block traffic. He was put in a civilian jail overnight and then was released to the Air Force. He was frightened, agitated, and suffering from gross paranoid delusions. We treated him with phenothiazines and he improved in a satisfactory way. However, I allowed his lawyer to persuade me that he was not competent to stand trial. With a statement from me, charges against him were dropped. The patient immediately decompensated, becoming totally disorganized and rather manic. He was given 2,000 mg. of chlorpromazine (Thorazine) a day with no effect and was transferred to another facility where various phenothiazines and lithium met with indifferent results. There was no immediate prospect for release from inpatient care. I cannot help but wonder that had we not prevented him from standing trial, he would have sustained his remission.

Conclusions

I have presented these cases as examples in which the actions of the psychiatrist have had a profound influence not only on the immediate situation, but also, I believe, on the life-style of the individual. "Goethe said, 'When we take man as he is, we make him worse; but when we take man as if he were already what he should be, we promote him to what he can be'" (2, p. 18). Although the individuals discussed here were not better off in jail than out, to allow them to use such pathologic manipulations to get out of jail was to reward a piece of behavior and to encourage a life-style that would be, by most standards, undesirable. The influence of the psychiatrist may be great when he is in a situation where people attempt to manipulate him. His potential ability to counter-manipulate in a therapeutic manner should be kept in mind.

REFERENCES

1. Whitaker C, Malone T: The Roots of Psychotherapy, cited in Chessick R: How Psychotherapy Heals. New York, Science House, 1969
2. Frankl V: Psychotherapy and Existentialism. New York, Simon and Schuster, 1967

Drug Flashbacks: Reported Frequency in a Military Population

BY M. DUNCAN STANTON, PH.D., AND ALEXANDER BARDONI

An anonymous drug questionnaire was administered to 2,256 men enlisted in the Army who were either entering or leaving Viet Nam. The percentage of respondents who reported flashbacks arising from the use of "acid" (LSD and STP) was 23 percent; amphetamines, five percent; and marijuana, one percent. The majority of men attributing flashbacks to drugs other than acid had also used acid. No relationship was found between reports of flashbacks and frequency of acid use, exposure to a combat zone, or birth order.

THE CHARACTERISTICS, symptoms, and dynamics of "flashbacks" following the use of psychedelic and other drugs have been discussed by a number of authors (1-12). However, little research has emerged that accurately documents the prevalence of such experiences in a more or less normal population. The studies that have taken such an approach have produced a variety of different estimates, due partly to differences in sam-

pling. To date, surveys of "normal" groups of subjects who had used LSD or related hallucinogens have yielded the following percentages of reports of flashback: Blumenfield (1), 20 percent (N=422); Horowitz (6), 28 percent (N=25); and Owens and associates (13), approximately 25 percent (N=395). McGlothlin and associates (14) obtained reports that 53 percent of their 24 subjects experienced some "lasting effect" from LSD, although it is unclear whether these were flashbacks or attitude changes. Studies of nonnormal populations include research by McGlothlin and Arnold (9) on 247 subjects, half of whom were psychotherapy patients. Of the subjects, 15 percent reported having had flashbacks. Among 34 patients admitted to the hospital for LSD problems, Robbins and associates (15) estimated that 32 percent had had flashbacks. Ungerleider and associates (16) surveyed adverse reactions to LSD among patients in Los Angeles County but provided no figures on the extent of total drug use from which the frequency of flashbacks could be estimated. With the exception of Blumenfield (1), none of the research efforts mentioned here has taken a statistical approach to flashbacks that have been attributed to drugs other than hallucinogens.

The purpose of the present study was to obtain estimates of flashback occurrences among a normal population of young adult men. Most of the major drugs of abuse were surveyed, and the relationships between "acid" (LSD and STP) flashbacks and such variables as frequency of use, birth order, and experience in a combat zone were also investigated. It should be noted that the high prevalence of drug use in this population (especially marijuana [17]) affords data on

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Opinions expressed herein are those of the authors and do not necessarily reflect the views of the Department of the Army or of the Department of Defense.

TABLE 1
Number of Subjects Who Attributed Flashbacks to One or Two Drugs (N = 88)

CATEGORY	ACID	SPEED	MARIJUANA	OPIUM	MESCALINE, PEYOTE, AND PSILOCYBIN	HEROIN/ MORPHINE	BARBITURATES	OTHER
One drug	48	11	9	4	3	3	1	2
Two drugs:								
Acid plus—		3		1	1			
Speed plus—			1					
Marijuana plus—				1				

the recent controversy over the occurrence of flashbacks among users of nonhallucinogenic drugs (1, 7, 8, 12, 16, 18).

Method

An anonymous drug questionnaire was administered¹ to 2,256 men (grades E-1 through E-6) enlisted in the Army. The questionnaire was given at a replacement station in South Viet Nam during November 1969. Approximately half (1,151) of the respondents were leaving Viet Nam after completing a tour of duty, and the remainder (1,105) were entering the country to begin an assignment. An age criterion of 26 or younger was employed in order to exclude the few older men in the groups and to make the sample more homogeneous. Of the questionnaires for the outgoing men, 150 were rejected for incompleteness, blatant inconsistencies, or failure to meet the age criterion; 105 of those for the incoming men were similarly rejected. The final sample consisted of 1,001 outgoing and 1,000 incoming men, for a total of 2,001. The number of users for each drug was also determined.

The questionnaire asked for the history of drug use of the respondents, along with basic demographic information such as age, birth order, etc. The important question for this study was: "Have you ever had 'flashbacks' from drug use? If so, please name these drugs." A more detailed discussion of the methodology employed in administering the questionnaires has been presented elsewhere (7). Suffice it to say that considerable precaution was taken to ensure anonymity and to convince the respondents of the credibility of the investigators.

Results

A total of 95 respondents reported experiencing flashbacks. Eighty-eight of them listed one or two drugs as sources; these data are presented in table 1. Four respondents reported having flashbacks but did not name the drugs, and two men named three drugs, listing either marijuana or opium in addition to amphetamines (speed) and acid; the data on these six men were excluded from table 1. In addition, one man who reported an acid flashback but no drug use of any kind was excluded from the study, bringing the total number of men who reported having had flashbacks to 94.

When viewed alone, these data are not particularly instructive. One must, of course, know something about the extent of drug use itself before making assertions as to the extent of flashbacks among users. Consequently, reports of flashbacks were compared with the overall reported use of certain drugs (table 2). In addition, since acid has been the drug of major concern in research on flashbacks, table 2 includes the percentage of men who attributed flashbacks to drugs other than acid but who had also had at least one experience with acid.

Among the 115 outgoing men who were acid users, 28.6 percent reported flashbacks that they attributed to acid or any other drug. The percentage for incoming acid users was 29.6 percent. A chi-square analysis between these two groups was not significant. This would indicate that exposure to a combat zone did not appreciably change the prevalence of reporting flashbacks among acid users since nearly all of the outgoing men had spent at least a year in Viet Nam.

Of the group of outgoing acid users, a somewhat higher percentage of flashback was reported (37.5 percent) among those who had used acid both before and during their

¹ The data were gathered while Dr. Stanton was with the 98th Medical Detachment in Viet Nam.

tour of duty in Viet Nam as compared with those outgoing acid users who had taken it either only before coming to Viet Nam (25.3 percent) or only during their tour there (28.5 percent). Chi-square analysis among these three groups yielded a value that was not statistically significant. The same group who had used acid before and during their tour was also compared separately with each of the other groups, again without significant results.

Three different analyses were performed to determine if a relationship existed between the extent (frequency) of acid use and the tendency to report flashbacks from any drug. First, three chi squares were calculated for the acid users within the outgoing ($N = 115$), incoming ($N = 125$), and combined incoming and outgoing groups ($N = 240$). To allow direct comparison with the study by McGlothlin and Arnold (9), the analysis was made across two levels of acid use, those who used it from one to ten times and those who used it 11 or more times. The results were not significant. The second analysis compared reports of flashbacks for all acid users ($N = 240$) across six levels of usage (1-5 times, 6-10 times, 11-20 times, etc.); outgoing and incoming users were combined because there were too few of them at the various levels to allow separate comparisons. The chi-square value obtained was not significant. Finally, point biserial correlations were computed for the outgoing, incoming, and combined groups between reports of flashbacks and the extent of acid use, in an attempt to determine whether a linear relationship existed between these two variables. The highest of these correlations was .08, and none of them was significant.

Three other analyses were performed that were identical to the three just described, with one exception: These subsequent analyses

compared the extent of acid use and the tendency to attribute flashbacks specifically to acid, as opposed to any drug including acid. Once again, however, no significant relationships of any kind emerged from the data. In summary, then, these six analyses provided no evidence that frequent acid use increases the likelihood of reporting flashbacks.

In order to ascertain whether birth order was in some way associated with the tendency to report flashbacks, a chi-square analysis was performed between firstborn and later-born acid users. Failure to indicate their birth order led to the exclusion of two respondents. Analysis was done on the combined group of 238 incoming and outgoing acid users. The difference was not significant.

Discussion

It is felt that the data reported here provide a fairly consistent representation of the percentage of youthful drug users who report flashback phenomena for each of the several drugs surveyed. Partial support for this is provided by the close similarity between our own figure among acid users of nearly 23 percent and the estimates of 20 percent and 25 percent obtained by Blumenfield (1) and Owens and associates (13), respectively, from samples comparable as to number and age of respondents. This suggests that slight differences in methodology may not be crucial in surveys of flashback phenomena.

Some of the percentages of flashbacks, e.g., that for speed, were greater than we had anticipated from our clinical experience. Although heavy use of amphetamines has occasionally been known to bring about such recurrent effects as paranoid thoughts, auditory hallucinations, and disorientation (2, 5), these are more frequently viewed as manifes-

TABLE 2
Comparison of Acid Use, of Other Drug Use, and of Flashbacks

DRUGS	TOTAL NUMBER OF USERS	THOSE WHO REPORTED FLASHBACKS		ACID USERS AMONG THOSE WHO REPORTED FLASHBACKS	
		NUMBER	PERCENT	NUMBER	PERCENT
Acid (LSD, STP)	240	55	22.9	55	100.0
Speed (amphetamines)	319	17	5.3	10	58.8
Marijuana	877	12	1.3	3	25.0
Opium	236	7	2.9	4	57.1
Mescaline, peyote, and psilocybin*	—	4	—	3	75.0
Heroin/morphine	76	3	3.9	0	—
Barbiturates	254	1	0.3	0	—

*Information on use of these drugs was not requested of the subjects. Nonetheless, four attributed flashbacks to them.

tations of psychosis and do not have the "drug" quality usually associated with flashbacks (11). Conversely, the attention given in recent years to flashback-type effects attributed to marijuana (1, 7, 8, 12, 16) initially led us to speculate that along these lines, our sample would certainly yield a figure higher than 1.3 percent, especially when one considers that half of the sample was leaving a milieu notorious for its high incidence of marijuana use (17). In fact, our results are in line with those of Tennant and Groesbeck (18), who could not document the occurrence of flashbacks among subjects who had used only cannabis. These findings demand that reconsideration be given to the entire issue of marijuana aftereffects, with special attention to the personalities and possible psychotic predispositions of those who report such phenomena.

It is noteworthy that, except for marijuana, the majority of respondents who attributed flashbacks to drugs other than acid also reported having used acid at some point in their lives. Whether they experienced the flashbacks before, shortly after, or a long time after using acid could not be determined from our questionnaire and is a question deserving further study. Nonetheless, it is possible that in some cases other drugs are being blamed for aftereffects that actually arise from the use of LSD and similar hallucinogens. Further, multidrug use and the frequent impurities, mixtures, and mislabelings that characterize many of the substances used illicitly today tend to cloud the issue of just what drugs a person may have used. A case in point is the recent discovery in California that a popular substance being sold to youths as peyote turned out, under analysis, to be nothing less than LSD.

A number of authors have claimed that frequent use of LSD is more predisposing to flashbacks than rare or occasional use of this drug (1, 6, 9, 10, 11, 15). Blumenfield (1) found that flashbacks were reported more frequently among heavier users. McGlothlin and Arnold (9) also presented data to support this point. Of their subjects who had used LSD fewer than ten times, 12 percent reported LSD-like recurrences; of those who had used it ten times or more 24 percent reported these recurrences. On the other hand, several different analyses of our own data did not support this finding. The figures we obtained were 28

percent for those who had used LSD one to ten times and 30 percent for those who had used it 11 times or more; the two figures did not differ significantly.

There appears to have been an increase during recent years in the number of infrequent drug users who report flashbacks in that many of the subjects in McGlothlin and Arnold's study were exposed to LSD only before 1961, while our data were gathered in late 1969. Whether this increase is due to 1) heightened awareness and expectation of flashbacks, 2) more accurate reports of flashbacks, 3) changes in the pharmacological composition of present-day hallucinogens, 4) multidrug use, or 5) some other factor is difficult to ascertain.

Despite the belief of some researchers that LSD flashbacks tend to increase under stressful conditions (1, 6, 10, 11), we found that exposure to a combat zone did not appreciably change the number of acid users reporting flashbacks. The low prevalence of marijuana flashbacks also tends to weigh against the stress theory. Thus, in contrast to Blumenfield's (1) assertion that "stresses of adjusting to the military setting" evoke flashback phenomena, our results indicate that the Viet Nam war experience, like birth order, is not correlated with the frequency of flashbacks.

We inevitably arrive at the question of defining what exactly a flashback is. There has been some debate on this issue (6, 9, 10, 11, 12, 15). The term may be overinclusive considering the difference in pharmacologic effects of the several drugs to which flashback phenomena have been attributed. However, it is doubtful that the respondents in our own or others' research have read the recent scientific and professional literature on flashbacks. They may not be in a position to critically evaluate the subjective experiences to which they assign the term "flashback." Thus, in the present study and elsewhere we are dependent upon the consumer and left with definitions that have been set forth and elaborated on primarily by a subgroup known as the "drug culture."

REFERENCES

1. Blumenfield M: Flashback phenomena in basic trainees who enter the US Air Force. *Milit Med* 136:39-41, 1971
2. Cohen S: Crime in America—why 8 billion amphet-

- mines? Cited in Amphetamines: Fourth Report by the Select Committee on Crime, US House of Representatives Report no 91-1807, January 2, 1971. Washington, DC, US Government Printing Office, 1971, pp 9-10, 22
3. Cohen S, Ditman KS: Prolonged adverse reactions to lysergic acid diethylamide. *Arch Gen Psychiat* 8:475-480, 1963
 4. Fischer R: The "flashback": arousal-statebound recall of experience. *Journal of Psychedelic Drugs* 3:31-39, 1971
 5. Gardner R: Psychic effects of amphetamine abuse, cited in Amphetamines: Fourth Report by the Select Committee on Crime, US House of Representatives Report no 91-1807, January 2, 1971. Washington, DC, US Government Printing Office, 1971, pp 11-14
 6. Horowitz MJ: Flashbacks: recurrent intrusive images after the use of LSD. *Amer J Psychiat* 126:565-569, 1969
 7. Keeler MH: Adverse reactions to marijuana. *Amer J Psychiat* 124:674-677, 1967
 8. Keeler MH, Reifler C, Riptzin M: Spontaneous recurrence of marijuana effect. *Amer J Psychiat* 125:348-386, 1968
 9. McGlothlin WM, Arnold D: LSD revisited—a ten-year follow-up of medical LSD use. *Arch Gen Psychiat* 24:35-49, 1971
 10. Rosenthal S: Persistent hallucinosis following repeated administration of hallucinogenic drugs. *Amer J Psychiat* 121:238-244, 1964
 11. Shick JF, Smith D: Analysis of the LSD flashback. *Journal of Psychedelic Drugs* 3:13-19, 1970
 12. Woody G: Visual disturbances experienced by hallucinogenic drug abusers while driving. *Amer J Psychiat* 127:683-686, 1970
 13. Owens KL, Black S, Wolff RP: Flashback patterns among military subjects. Fort Sill, Okla, 1969 (unpublished research study)
 14. McGlothlin W, Cohen S, McGlothlin MS: Long-lasting effects of LSD on normals. *Arch Gen Psychiat* 17:521-532, 1967
 15. Robbins E, Frosch W, Stern M: Further observations on untoward reactions to LSD. *Amer J Psychiat* 124:393-395, 1967
 16. Ungerleider T, Fisher D, Goldsmith S, et al: A statistical survey of adverse reactions to LSD in Los Angeles County. *Amer J Psychiat* 125:352-357, 1968
 17. Stanton MD: Drug use in Vietnam: a survey among Army personnel in the two northern corps. *Arch Gen Psychiat* 26:279-286, 1972
 18. Tennant FS, Groesbeck CJ: Psychiatric effects of hashish. *Arch Gen Psychiat* 27:133-136, 1972

The Psychology of Hallucinogenic Drug Discontinuers

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Psychological test data from individuals who had discontinued using hallucinogens with those from individuals who were still using them were compared. While the continuers had a tendency toward higher risk-taking behavior, the two samples could not be otherwise psychologically differentiated. Between two subsamples with moderate drug experience, the continuers showed a greater trend toward psychiatric impairment than the discontinuers. The authors do not believe that drug experiences impaired the discontinuers.

of young people in the Boston-Cambridge community were no longer using hallucinogenic drugs. We wondered whether the discontinuers represented a subsample of the drug-taking population and whether they differed from non-drug users. We wondered, if hallucinogenic drug use produces psychopathological consequences, whether such

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MOST STUDIES concerning users of illicit hallucinogenic drugs focus upon the period of drug use. We became interested in the phenomenon of drug discontinuance through a growing awareness that increasing numbers

TABLE 1
Characteristics of the Samples

ITEM	DISCONTINUERS (N = 16)	CONTINUERS (N = 16)
Sex		
Male	11	13
Female	5	3
Religious background		
Protestant	8	12
Catholic	2	0
Jewish	6	4
Occupation		
Student	6	2
Employed	7	4
Housewife	2	0
Unemployed	1	10
Mean age	25.3 years	23.7 years

changes would still be evident after a period of discontinuance. This paper will focus upon these questions; the reasons for drug discontinuance will be considered in a separate communication.

To our knowledge only Blum and associates (1) have considered studying drug discontinuers for research purposes. On psychological test variables, discontinuers as compared with continuers were found to be "over-controlled," less trusting and naïve, and more suspicious. The discontinuers were found to have fewer personality disorders as judged by a rater, although they were not asked to rate themselves in this regard. Other characteristics that differentiated the two groups included a wider use of hallucinogens other than LSD among the continuers and more group ethnocentrism ("LSD users cling together"). There was some reduced job efficiency among members of both groups. McGlothlin and Arnold (2), in a follow-up study of 247 LSD users, noted that 58 had discontinued drug use although they did not specify the criteria for discontinuance. On the basis of interview and questionnaire data, LSD users showed no lasting adverse or beneficial effects but were considered to be high-risk takers.

For the purposes of our study, the following *a priori* criteria were established. In order to be considered a drug user a subject had to have had at least two experiences with some hallucinogenic substance, defined as LSD, mescaline, or psilocybin. Drug discontinuers had to have abstained from hallucinogenic drug use for at least six months. (In fact, nine of the 16 discontinuers had not used any of these drugs for one or more years.)

The Subjects

A group of 16 drug discontinuers and one of 16 continuers were referred to us for study by colleagues in the Boston-Cambridge metropolitan area. Identifying characteristics and occupational histories of the two populations are shown in table 1. Although the two populations were not matched, they are similar in age, sex, and religious background. The discontinuers were significantly more involved in goal-directed activity than were the continuers ($\chi^2 = 8.87$, $df = 1$, $p = .003$).

Table 2 summarizes the histories of illicit drug use in both groups of subjects. Except for hallucinogenic drug use the groups were essentially alike. All subjects were frequent users of marijuana (about twice a week on the average), and all were using marijuana at the time of the study. (Many remarked that they did not consider marijuana a drug as compared with the hallucinogens; the discontinuers did not consider discontinuing the use of marijuana.) Members of each group tended to experiment with many different types of illicit drugs, although they tended not to repeat such experimentation more than a few times. The groups differed greatly, however, in the frequency of hallucinogenic drug use. Figure 1 displays the frequency distribution of the two groups. It is clear that the discontinuers tended to have many fewer hallucinogenic experiences than the continuers.

Method

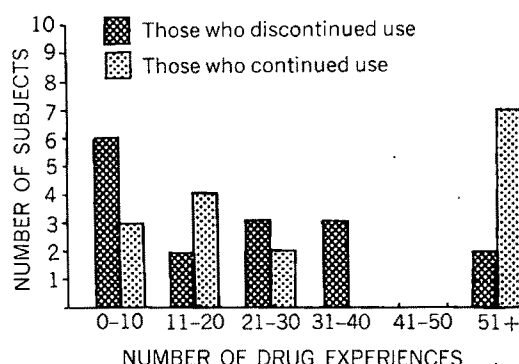
Psychological data were derived from self-rated paper-and-pencil tests that have been frequently used in our laboratory and found to be sensitive to psychiatric symptoms and

TABLE 2
History of Illicit Drug Use

SUBJECTS	DISCONTINUERS	CONTINUERS
Those admitting frequent marijuana use (several times a week)	16	16
Those admitting amphetamine experimentation	12	13
Those admitting barbiturate experimentation	5	2
Those admitting opiate experimentation	10	9
Those admitting cocaine experimentation	7	10
Mean number of hallucinogen experiences	22.4	69.9

FIGURE 1

Frequency Distribution of Drug Use:
Discontinuers Versus Continuers



impairment in a population of young, non-patient volunteers for various research projects. Three broad classes of tests were included^{1,2}: tests that assessed specific mood states, general psychological adjustment-maladjustment tests, and tests that assessed specific personality traits or variables.

Mood Instruments

Minnesota Multiphasic Personality Inventory (MMPI) Depression scale (D₆₀): a 60-item measure of symptomatic depression (7). Normative data from our laboratory suggest that a mean score of 19.43 characterizes a population of men who are comparable in age and other demographic variables to the present research samples.

Dempsey's modification of the MMPI Depression scale (D₃₀): a 30-item, shortened form of the D₆₀ scale, which omits items of bodily health and somatic concern (8). A mean score of 6.01 characterizes the normative male population from our laboratory.

Taylor Manifest Anxiety Scale (TMAS): a 50-item scale designed to assess characterological anxiety (9). A mean score of 13.21 characterizes the normative male population.

¹ A number of other psychological measures were included for exploratory purposes. These tests included the Scheier-Cattell Anxiety Battery (3), the Femininity Scale of the California Psychological Inventory (4), the Eysenck Personality Inventory (5), and the Psychiatric Outpatient Mood Scale (6). There were no differences between the research populations nor were these subjects different from normative reference populations.

² Since male and female subjects rate themselves differently on these measures, only male subjects from each group were statistically compared.

Adjustment Tests

The Langner Scale: a 22-item, self-rated measure of psychiatric impairment (10). Langner found that a score of four or more symptoms characterized impaired psychiatric health. We have found the scale useful in differentiating impaired subjects from healthy volunteer subjects.

Specific Personality Variable Scales

Wallach-Kogan Choice-Dilemmas (risk-taking): a 12-item measure of risk taking developed in 1959 (11) and modified by Kochansky (12). Each item represents a choice between a risky and a safe course of action for a specified situation. A subject's selection of a particular probability level of the success of a risky alternative reflects the *deterrence of failure* for him. Higher scores are associated with greater risk-taking *conservatism*. In addition to a total score, it is possible to derive three subscales. The self-destructive subscale (S-D) is based upon those four items in which risk of one's own life or physical well-being is the primary risk component. The other two subscales are comprised of items involving primarily financial (F) or achievement (Ach) risks.

Results

The psychological test data are summarized in table 3. Only one significant difference emerged between the two groups, although the discontinuers scored slightly higher on the Depression scale of the MMPI and its modification by Dempsey. The two groups did not differ substantially from normative data derived from our laboratory population of young, volunteer subjects drawn from the Boston-Cambridge community or from published normative values. On

TABLE 3
Psychological Tests

TEST	MALE DISCONTINUERS (N=11)	MALE CONTINUERS (N=13)
D ₆₀	21.45	19.08
D ₃₀	7.82	7.23
TMAS	13.00	15.85
Langner	2.91	3.08
W-K, self-destructive factor*	26.36	21.15

*The lower score indicates greater risk-taking behavior.

TABLE 4
Psychological Tests Controlled for
Moderate Drug Usage

TEST	MALE DISCONTINUERS (N=6)	MALE CONTINUERS (N=4)
D60	19.80	29.50*
D30	8.00	13.50**
TMAS	14.00	25.25*
Langner	2.40	6.00**
W-K, self-destructive factor	29.00	28.00***

* $p < .05$, two-tailed, $df = 7$.

** $.05 < p < .1$, two-tailed, $df = 7$.

***n.s.

the self-destructive factor of Wallach and Kogan's Choice Dilemmas questionnaire, however, the drug continuers scored significantly lower than the discontinuers, reflecting a tendency toward more risky behavior in situations involving the risk of loss of life or severe physical injury ($p < .05$, two-tailed).

Discussion

Taking all 24 male subjects together, the results of the psychological tests generally agree with those of previous workers. Failure to find any significant elevation among drug users on the Depression scale of the MMPI was also reported by Ungerleider and associates (13), McAree and associates (14), Smart and Jones (15), and Barron and associates (16). These workers employed the entire MMPI and observed that elevations were either inconsistent or were recorded in the Psychopathic Deviate, Schizophrenia, or Mania scales only. The lack of elevation on any of the administered psychological test measures would indicate that, as a group, these young people did not rate themselves as emotionally or psychiatrically symptomatic. On the basis of the mean results of these tests, neither continuers nor discontinuers could be distinguished from a larger normative population of the same age and demography.

Of considerable interest, however, is the finding of a significant difference between discontinuers and continuers regarding self-destructive, risk-taking behavior. Drug continuers appeared to show more signs of risk-taking behavior on Choice-Dilemmas items involving possible loss of life or bodily injury than were those who had discontinued drug use. On the basis of these data, we concluded

that active users of hallucinogenic drugs may be characterized by greater propensity toward risk-taking behavior in a variety of situations involving life or bodily injury than individuals who have discontinued using these drugs. It may be that drug users underestimate or misjudge the probability of the negative outcome of a risk-taking decision involving their health. Alternatively, the drug user who is a high-risk taker may value his life or physical well-being less than the discontinuer. One can speculate that the decision to discontinue hallucinogenic drug use is, in part, associated with a general shift toward increasing conservatism in health-threatening situations.

Since there was a disparity between the number of hallucinogenic drug experiences among members of each group, we decided to compare those discontinuers and continuers with approximately the same number of hallucinogenic drug experiences. When the data are reexamined for subjects who have had between 11 and 30 experiences (see figure 1), the differences in risk-taking behavior disappear, but symptomatic differences emerge. The relevant differences are shown in table 4. Continuers in this middle range of drug use rated themselves as significantly more depressed, anxious, and psychiatrically impaired than the discontinuers.

Interpretation of these data, derived from exceedingly small samples, can only be tentative. We suggest that when the number of drug experiences is held constant, discontinuers more resemble the normative reference population on three measures of affective symptomatology and psychiatric health, while the continuers resemble mildly symptomatic persons who are aware of their internal distress and respond to self-rated paper-and-pencil tests.

Among the continuers explanations for the appearance of symptoms in the mid-range of drug use and for the disappearance of risk-taking differences must also remain speculative. We offer the following hypotheses for future testing: Moderate hallucinogenic drug use may not be seen as risk-taking behavior and may, in fact, be associated with perceived dystonic psychiatric symptoms and distress (for example, search for goal direction, intimacy, identity, creativity). Those who use hallucinogenic drugs with greater frequency may not perceive inner psychic distress. For these users, hallucinogens may be a risk-taking

event, an additional stimulation beyond the drug experience per se. Since the distribution of the frequency of drug experiences was so skewed in our population that continued drug use, the psychological test scores of the non-symptomatic, high-risk heavy users would statistically dominate the moderate-use, symptomatic low-risk continuer and obscure the differences.

These suggestive explanations are consonant with the work of previous investigators. As we have noted, interpretations of previous psychological test data indicate that heavy hallucinogenic drug users tend to be described in terms of inconsistent diagnostic patterns or character structure and pathology, rather than symptomatic psychoneuroses with inner conflict. The tendency toward drug use as an ego-syntonic risk-taking adventure corroborates McGlothlin and Arnold's general observations (2). They characterized hallucinogenic drug users as persons who preferred loosely structured lives and who had a proclivity for risk-taking experiences.

From these data, there is no way to correlate discontinuance with changes in psychiatric symptomatology or impairment. One may speculate, however, that the symptomatic pathology seen among moderate drug continuers is not necessarily irreversible. If continuers who use hallucinogens moderately are similar to discontinuers except in continuance of drug use, then one may note a decrease in symptoms and an increase in goal-directed behavior associated with discontinuance. Three explanations are possible. First, hallucinogenic drug use did indeed solve problems for which the use was intended. Second, and more probable, when dystonic affective experience diminishes for any reason, the need for hallucinogenic drug use concomitantly declines. Third, it may be that drug use itself produces the psychiatric symptoms; when drug use ceases, so do the symptoms. It is most likely, however, that explanations for drug discontinuance are more diverse and more complex.

We can conclude that the 16 subjects who had used hallucinogenic drugs and had discontinued this use were not permanently impaired as indicated by psychological test measures, by their involvement in goal-directed activity, and by a lower tendency to make high-risk decisions that might be detrimental to their health.

Summary

Psychological test data from 16 discontinuers of hallucinogenic drug use are presented and compared with similar data from a nonmatched sample of drug continuers. As a group, discontinuers as well as continuers did not differ from a normative reference population in psychological test scores. Except for a higher tendency toward health-threatening, risk-taking behavior among the continuers, the two research populations could not be psychologically differentiated. Within the two population samples, five discontinuers and four continuers who had approximately equal moderate hallucinogenic drug experiences were compared. When the frequency of drug use was controlled in this manner, the differences in risk-taking behavior disappeared, but the continuers scored significantly higher on measures of depression and anxiety, with a trend toward greater psychiatric impairment. It is suggested that moderate hallucinogenic drug use is associated with ego-dystonic affective experience and is not seen as a health-threatening risk activity. Heavy drug use, primarily among the continuers, is seen as a high-risk activity that is ego syntonic, thus suggesting character pathology. Hallucinogenic drug discontinuance is probably a complex phenomenon that defies a simplistic explanation; the 16 discontinuers studied cannot be considered impaired by their drug experience.

REFERENCES

1. Blum R, Blum E, Funkhouser ML: LSD "regulars": continuing users compared with discontinuers, in *Utopiates*. Edited by Blum R. New York, Atherton Press, 1964, pp 69-89
2. McGlothlin WH, Arnold DO: LSD revisited: a ten-year follow-up of medical LSD use. *Arch Gen Psychiat* 24:35-49, 1971
3. Scheier IH, Cattell RB: *Handbook and Test Kit for the IPAT 8-Parallel-Form Anxiety Battery*. Champaign, Ill, Institute for Personality and Ability Testing, 1960
4. Gough HG: *California Psychological Inventory*. Palo Alto, Calif, Consulting Psychologists Press, 1964
5. Eysenck HJ, Eysenck SBG: *Eysenck Personality Inventory*. San Diego, Educational and Industrial Testing Service, 1968
6. McNair DM, Lorr M, Droppleman LF: *Psychiatric Outpatient Mood Scale*, revised ed. Boston, Psychopharmacology Laboratory, Boston University Medical Center, 1971
7. Hathaway SR, McKinley JD: *Minnesota Multipha-*

- sic Personality Inventory: Manual. New York, Psychological Corp, 1951
8. Dempsey P: A uni-dimensional depression scale for the MMPI. *J Consult Psychol* 28:364-370, 1964
 9. Taylor JA: A personality scale of manifest anxiety. *J Abnorm Soc Psychol* 48:285-290, 1953
 10. Shader RI, Ebert MH, Harmatz JS: Langner's psychiatric impairment scale: a short screening device. *Amer J Psychiat* 128:596-601, 1971
 11. Kogan N, Wallach MA: Risk-Taking: A Study in Cognition and Personality. New York, Holt, Rinehart & Winston, 1964
 12. Kochansky G: Risk-taking and hedonic mood stimulation in suicide attempters. Boston, Department of Clinical Psychology, Boston University, 1970 (unpublished doctoral dissertation)
 13. Ungewitter JT, Fisher DD, Fuller M, et al: The "bad trip"—the etiology of the adverse LSD reaction. *Amer J Psychiat* 124:1483-1490, 1968
 14. McAree CP, Steffenhagen RA, Zheutlin LS: Personality factors in college drug users. *Int J Soc Psychiat* 15:102-106, 1969
 15. Smart RG, Jones D: Illicit LSD users: their personality characteristics and psychopathology. *J Abnorm Psychol* 75:286-292, 1970
 16. Barron SP, Lowinger P, Ebner E: A clinical examination of chronic LSD use in the community. *Compr Psychiat* 11:69-79, 1970

DISCUSSION

GEOGE S. GLASS, M.D. (Bethesda, Md.)—This paper focuses on the relation between psychedelic drug use and certain parameters of personality. These specific characteristics are psychopathology, internal measures of anxiety and depression, and risk-taking expressed in part by self-destructive tendencies. The notion that the heavy drug user may have self-destructive tendencies has not been expressly studied but is supported by one's own clinical cases and by the term used to describe drug taking, i.e., "blowing one's mind."

While there are many reasons for psychedelic drug usage, an important one is a desire for self-exploration in hope of some decrease in dysphoric symptoms and of a change in an individual's personality. Among individuals who do altogether stop their use of psychedelic drugs, some report their drug experiences as useful and some as non-useful. In what respects these drug discontinuers differ from continuing users is still uncertain.

This paper suggests that the two groups are essentially similar and are not very different from average youth, apart from a willingness to take risks. However, a comparison of moderate drug users suggests that there are many differences between the drug user and the drug discontinuer. Unfortunately this study has still not completely resolved the issue for two reasons: 1) the size of the studied subgroup of nine subjects is far too small to draw many accurate conclusions; and 2) the paper-and-pencil tests that were administered were specific and circumscribed, while the continued taking of

drugs is a complex issue related to many factors, both intra- and extrapsychic. These include the individual's premorbid psychopathology, the types of defenses he uses, his current intrapsychic state, his past drug experiences, his family structure, and the sociological context he lives in, with the availability of drugs, the mores of the setting, and the environmental stress around him all having some importance (1-3). These parameters are varied and diffuse, but a more detailed questionnaire relating to this demographic material and a short structured interview could have provided some of this information.

For instance, did drug use begin during a time of crisis, as a mode of relating to others, or for some other reason? Does the frequency of drug use slowly taper off as the individual loses interest in a novelty or realizes that it is not useful in problem solving? Or does drug use conflict with other interests like work, or does the individual have one or two bad trips that point out to him the risks involved? Does a bad trip cause an individual to decide that the risk is not worth it?

In fact, there is some evidence that drug discontinuers are a different type of individual than continuers, although there is little information in the present study to support this. The concept of different populations is demonstrated in part by McGlothlin and Arnold, who recently reported on a study of a large population (1). They found that psychedelic drug use is usually time-limited in asymptomatic people and that when the novelty wears off, a drug experience becomes just that—a trip—such that after one has visited there for a while, he loses interest.

Whether the lower risk assessment found in continuing users is due to their having had no bad trips or to their increasing passivity as a result of a bad trip that causes them to go "with" the drug is an interesting question. An interview or a more detailed questionnaire might clarify these points. Apparently, drug continuers see drug ingestion as a mode of coping, of reacting to situations, and not as deleterious to their health. The question remains, however, whether discontinuers and users begin and continue drug use for different reasons.

Also of interest is the authors' report of significant differences between the two groups of moderate users in terms of psychopathology and intrapsychic discomfort, while individuals who became heavy drug users seemed to revert back to a normal adjustment picture, rating themselves as having few symptoms and little depression or anxiety. A clinician's evaluation of these individuals' psychopathology would have given a more objective picture of their mental status than self-ratings alone.

The authors suggest several reasons why heavy drug users reported low measures of psychopathology and dysphoria. Given their reliance on

self-ratings, a different explanation seems more suitable. This relates to the effect of the psychedelic drug on an individual's personality; this has been reported in the literature (4). Psychedelic drugs amplify affect, so that if one is dysphoric and then "trips," he may well have a bad experience (5). Those who use drugs frequently know this and learn either to avoid drug use at times of dysphoria or to assume a protective psychological stance. They deny and externalize their inner difficulties in an effort to maintain an inner state of affective neutrality. The drug effect reinforces this stance, and the overall result may be a change in personality. This change leads toward a more passive orientation toward life that emphasizes alloplastic rather than autoplasic defenses and a denial of inner discomfort and symptoms. This may have happened in the continuers who, in their self-ratings, reported no distress or psychopathology

but who might seem quite bizarre and upset to an observer.

REFERENCES

1. McGlothlin WH, Arnold DO: LSD revisited: a ten-year follow-up of medical LSD use. *Arch Gen Psychiat* 24:35-49, 1971
2. Cohen C, White E, Schoolar J: Interpersonal patterns of personality for drug-abusing patients and their therapeutic implications. *Arch Gen Psychiat* 24:353-358, 1971
3. Freedman D: On the use and abuse of LSD. *Arch Gen Psychiat* 18:330-342, 1968
4. Glass G, Bowers M: Chronic psychosis associated with long-term psychotomimetic drug abuse. *Arch Gen Psychiat* 23:97-103, 1970
5. Blacker K, Jones R, Stone G, et al: Chronic users of LSD: the acid heads. *Amer J Psychiat* 125:341-351, 1968

IN MEMORIAM

Thomas J. Heldt, 1883-1972

Dr. Thomas J. Heldt was born on August 8, 1883, in Buckeye, Iowa. He secured his B.A. and M.D. degrees at the University of Missouri. In 1914, already determined to become a psychiatrist, he entered Johns Hopkins University, where the renowned Adolf Meyer was Professor and Chairman of the Department of Psychiatry. In June 1916 he began his internship at Ward's Island, N.Y., where the great medical psychologists August Hoch and George Kirby, with neuropathologist Charles Lambert, were in charge of psychiatry at the Manhattan State Hospital and the New York Psychiatric Institute. He was then attending physician in the Department of Psychopathology of Cornell Medical College, N.Y.

Following his internship Dr. Heldt enlisted in the Army in June 1917, starting active duty in August. In February 1918 he was division psychiatrist of the 81st Division, seeing action in the Metz-Verdun drive. He was quickly promoted to captain, then major, in the Medical Corps, serving until July 1919.

From 1919 to 1922 Dr. Heldt was Clinical Director of the U.S. Public Health Service Hospital at Waukesha, Wis. He then started the first U.S.P.H.S. child guidance clinic in St. Louis, Mo., soon afterward establishing a second one in Norfolk, Va.

In June 1923 Dr. Heldt became Physician in Charge of the Division of Neuropsychiatry at the Henry Ford Hospital, Detroit. He developed fine departments of psychiatry and neurology that featured the dignity of human individuality and that fostered the integration of psychiatry, general

medicine, and religion. His was the first division of neuropsychiatry in a general hospital conducted entirely without physical restraints of any kind, without isolation of psychiatric patients, and without segregation of men and women—an achievement of world interest. He retired as head of the division on July 1, 1952, remaining on the staff as Senior Consultant.

Dr. Heldt received many awards and was elected to many offices. In 1950 he was president of the Central Neuropsychiatric Association; in 1925 and in 1946 he was president of the Michigan Society of Psychiatry and Neurology; and he served as assistant or associate examiner for the American Board of Psychiatry and Neurology annually between 1937 and 1955. From 1951 to 1965 he was a member of the Michigan State Board of Alcoholism.

Tom Heldt even succeeded in combining his chief sport and relaxation, hunting in the wilds, with his interest in scientific research: He provided a series of brain tissues contributing to phylogenetic studies of the development of the nervous system to the Department of Anatomy, University of Michigan.

I feel pride in having known this responsibly great physician, who completed his full life on August 21, 1972. Dr. Heldt is survived by three sons, Thomas F. of Albuquerque, N.M., Robert E. and Dr. Richard F. of Detroit; a sister, Hulda, of Sioux City, Iowa; six grandchildren; and three great-grandchildren.

JOHN M. DORSEY, M.D.



Austin M. Davies, 1900-1972

News of the sudden death of Austin M. Davies in Miami, Fla., on August 8 will awaken a flood of memories in the older members of the Association, for he was intimately connected with the business affairs of the APA from 1932 until his retirement in 1965—a span of 32 years. In fact, until the Washington office was opened in 1948, Austin was the Association's lone "general factotum."

It was not until 1932 that Dr. William L. Russell, then President of the Association, informed the members that it was time for the organization to have a home and also that it needed an executive assistant to look after its business affairs. The Association then numbered 1,416 members, of whom 80 percent were employed by state hospitals. It had no place to call its own—no office and no clerical help. The Council met twice yearly. Although its business transactions were published regularly, there was no one to carry on between meetings or from year to year; thus, along with other deficiencies due to this lack of continuity, much valuable historical material was lost.

Fortunately for all concerned, luck had it that an excellent candidate for the position of executive assistant was available in the person of Austin Davies, a graduate of Brown University (1922). Born in Philadelphia, he was the son of a clergyman and therefore, as Dr. C.B. Farrar noted, "It was not unnatural that he would have to help himself through college." In so doing, one of his jobs on weekends was as an attendant at Butler Hospital, where he worked for three years and became acquainted with and influenced by Dr. Arthur H. Ruggles. He was also influenced by his brother, Dr. Stanley P. Davies, the author of a book on mental deficiency. Austin wrote his senior thesis on the subject: "The Relationship of the Public to the Problems of Mental Illness." He did not know then that the best energies of his life would be devoted to the interest of the mentally ill and to the great American agency organized in their behalf.

When Mr. Davies began his duties the treasury of the Association was not robust enough to allow for renting office space, so as a temporary measure the National Committee for Mental Hygiene provided a rent-free haven for five years. Clifford Beers was the director of the National Committee at the time.

By 1937, Mr. Davies was able to advise the officers that the organization was strong enough financially to stand on its own feet, and quarters were secured first at the New York Academy of Medicine and then, after five years, at a more per-

manent locus at Rockefeller Center. The executive assistant was now in high gear and it was soon apparent that he was indispensable. One of his major tasks was to increase the nonmember subscription list of the *Journal* and to increase its advertising revenue, which in 1932 had amounted to \$336.24. By the time of his retirement this revenue had increased to \$200,000 yearly, and the number of nonmember subscribers had increased materially. The *Journal*, which had been a quarterly, became a bimonthly in the 30s and a monthly in 1947.

One of the executive assistant's most demanding tasks was planning and arranging the annual meetings and putting them on a self-sustaining basis through income from exhibitors and registration fees. In arranging the meetings he became acquainted with the virtues and failings of more than 200 hotels across the nation; it was estimated that he traveled over 25,000 miles yearly. The ease with which he handled the annual meetings, the fact that he seemed to be in several places at the same time, and his ability to work in pleasant symbiosis with various local arrangement committees were all virtues that were essential, and through them he excited the admiration of countless people.

Austin's New York office soon became a psychiatric crossroads, a central point for all manner of inquiries—data about members and prospective members, journalists seeking information, and worried families seeking the names of psychiatrists. He handled insurance of various kinds for members, dealt with publishers and the advertising agency, was business manager for the *Journal*, and withal seemed always to have the time to be helpful and courteous. He was a general information bureau; yet no matter how busy he might be he exhibited a personal and friendly interest in the individual inquirer that endeared him to all who had occasion to call upon him.

Different criteria and classes of membership for the APA were defined as the organization grew apace. Mr. Davies was an early supporter of the District Branch movement and spoke often of the advantages of grass-roots activities. As time moved on, his duties increased in geometric proportion. Although he looked a bit harried at meeting time, he was always able to handle difficulties that arose and to maintain his equanimity while doing so. Fortunately, he moved off the scene well before the meetings began to be disrupted by demonstrations. He would not have been able to abide that type of activity.

In 1957 the Association took note of his 25th anniversary in its service. Dr. Farrar, the distinguished editor of the *Journal*, paid him editorial homage. Dr. William Rush Dunton, the oldest living APA Fellow, wrote of Mr. Davies' courtesy, his skill, and his competence, adding: "Especially have we come to feel a warm and affectionate regard for him as a friend."

In anticipation of Austin's retirement he was made an Honorary Fellow of the APA and was presented with a handsome framed scroll, which read in part: "He supplied the energy to set forces in motion that brought our association to lofty position in American life. His tenure witnessed a tenfold growth in our membership. . . . We shall ever remember him affectionately as ambassador par

excellence to the leading hostelrys in the nation, in negotiation of our comforts, as genial host at our meetings, and raconteur of anecdote and chronicler of history, as shrewd guardian of our accounts, as champion of the individual members, and as friend, mentor, and counselor along the way."

Thus with the plaudits and affectionate regards of his colleagues, Austin retired to Florida. His last few years were concerned with the devoted care of his beloved wife, Alma (the former Alma Blank, an artist), who was ill. Emphysema hastened his demise but yet death, when it came, was sudden and a shock to all his friends.

F.J.B.

LETTERS TO THE EDITOR

Tardive Dyskinesia and the Rabbit Syndrome During Wakefulness and Sleep

SIR: Because of its resistance to treatment, persistent or tardive dyskinesia constitutes one of the most serious side effects associated with the long-term administration of neuroleptics. So far only tetrabenazine and reserpine appear to possess any real value in reducing or abolishing tardive dyskinesia (1). Another recently described neuroleptic-induced extrapyramidal reaction consists, in its typical form, of perioral movements that are strikingly similar to the movements of a rabbit's mouth (frequency range: 5-5.5 c/sec.) and is thus called the "rabbit syndrome" (2). Since the pathogenesis of these abnormal movements still remains obscure, a neurophysiological approach was utilized to study these phenomena in chronic schizophrenic patients by polygraphic techniques during wakefulness (N = 29) and sleep (N = 21). The tardive dyskinesias were classified according to a rating scale (3) that differentiated three types of tardive dyskinesias: 1) a choreo-athetoid syndrome, 2) a buccolingual syndrome, and 3) a buccolinguo-masticatory syndrome.

A difference was observed, with respect to the influence of attention concentration and motor performance, between the buccolingual and buccolinguo-masticatory syndromes and the rabbit syndrome. The intensity of the latter, which always augmented during attention concentration and motor performance, was accompanied by an increase in the tone of the muscles involved in these movements. The other types of oral dyskinesias (the buccolingual and buccolinguo-masticatory syndromes) were either enhanced or attenuated during attention concentration and motor performance. The muscle tone usually increased concomitantly with their attenuation. Their regularization was also seen during attention concentration and motor performance. Moreover, sometimes the rabbit syndrome superimposed itself on these dyskinesias during attention concentration and motor performance when the muscle tone augmented.

During sleep, all types of oral dyskinesias were absent during non-REM stages II, III, and IV and during the REM state. The rabbit syndrome persisted, however, during non-REM stage I. During

the transitory stages from sleep to wakefulness, all types of dyskinesias reappeared, the rabbit syndrome reappearing more precociously during the non-REM stage I.

These findings suggest that the mechanisms triggering the rabbit syndrome are similar to those involved in the pathogenesis of the parkinsonian syndrome (increase of the tremor with the augmentation of the tone of the muscles involved in the tremor and persistence of the tremor during the non-REM stage I) and seem different from those inducing the other types of oral dyskinesias. The fact that the antiparkinsonian agents relieve the rabbit syndrome to various degrees (2), whereas they are not only ineffective in the treatment of tardive dyskinesia but may even lead to an aggravation, would militate in favor of this hypothesis.

The references are:

1. Ayd FJ Jr: Treatment of persistent dyskinesia. *International Drug Therapy Newsletter* 7:9-11, 1972
2. Villeneuve A: The rabbit syndrome. A peculiar extrapyramidal reaction. *Canad Psychiat Ass J* 17 (Suppl): 69-72, 1972
3. Villeneuve A, Lavallée JC, Lemieux LH: Dyskinésie tardive post-neuroleptique. *Laval Méd* 40:832-837, 1969

K. JUS, M.D.
A. VILLENEUVE, M.D.
A. JUS, M.D.
Quebec, Quebec, Canada

Character and Behavior Disorder: A Way to Discharge Men from the Service

SIR: While preparing a topic for discussion recently, I encountered Dr. Peter G. Bourne's article "Military Psychiatry and the Viet Nam Experience" (October 1970 issue). This article brought to mind a fact that I felt should be realized by readers of material pertaining to military psychiatry. The statement was made that, in contrast to the high percentage of cases of "combat fatigue" seen in previous wars, 40 percent of the psychiatric admissions in Viet Nam were classified as having character and behavior disorders. While there is no reason to doubt the validity of this particular statement since it was ostensibly obtained from

Letters to the Editor are welcomed and will be published, if found suitable, as space permits. Please submit two copies (typewritten, double spaced), the length, if possible, not to exceed 500 words. Letters will be subject to the usual editing.

records of men seen by psychiatrists in a hospital setting, this is certainly not true in all cases within the Army.

The diagnosis of character and behavior disorder (personality disorders, in more recent terms) in the U.S. Army is, for the most part, a label given to persons whom the Army wishes to separate from service for one reason or another on a "212 discharge." These discharges are usually initiated by a company commander, and once initiated, little is done by any professional person to confirm or refute the "diagnosis." In fact, as indicated by the quotation of the following directive sent to all general medical officers at Fort Ord Army Hospital, the doctors are asked to rubber-stamp the "diagnosis."

1. Attached is a copy of DA Form 3822, the new Mental Status Evaluation Report, to be used by Troop Clinic physicians in clearing 212s.

2. Under "Impression" an additional statement is needed (no significant mental illness box is checked). This additional statement is "*Patient does have a character and behavior disorder.*"

3. Units want and need this statement to expedite the 212 processing. Unless this is done, unit commanders will insist on sending such cases to the Mental Hygiene Consultation Service in order to get the diagnosis of character and behavior disorder established.

This creates an added workload on Mental Hygiene Consultation Service.

While some of the men "diagnosed" in this manner undoubtedly do have personality disorders, many, if not the majority, do not. I personally was asked to sign such a request on a recruit whose only indication of a character disorder was his refusal to fire a weapon, which he did not wish to do because of his feelings regarding the sanctity of life. I refused to sign it, feeling that even in the United States, considering human life sacred did not constitute a personality disorder.

I would urge some caution, then, in the interpretation of statistics regarding military psychiatry, for after all, military medicine is military medicine.

RAYMOND B. KENNEDY, M.D.
Carmel, Calif.

Homicidal Acts of War

SIR: "Psychiatric Aspects of Homicide Prevention" by Dr. Emanuel Tanay (January 1972 issue) is an interesting paper on a neglected subject. However, two rather serious omissions prompted this letter.

Despite a well-thought-out classification system

of homicide, the most important form of homicide is not mentioned. I am referring to the individual and group homicidal acts of war. The ego-syntonic (for the most part) homicidal behavior of an army is a more proper setting for research because of the large volume of murders occurring per unit of time. Moreover, little progress in controlling civilian homicide can occur as long as the donning of certain irrelevant externals (e.g., uniforms) allows people to murder almost at will.

An altered state of consciousness secondary to alcohol is such an important factor in so many homicides that I feel it deserves special mention. In fact, if it were measurable, I predict that it would be a greater contributing factor than psychological dissociation. As an aside, it is basically the same type of person who wants to make a profit from selling guns who is comfortable making a living selling alcohol. In a society where owning property or possessing money is held in high esteem, a way will always be found to keep gun sales, alcohol sales, and amphetamine production legal.

GRIFFIN M. BATES, JR., M.D.
Rutland, Vt.

Those Who Kill Without Thinking

SIR: I read Dr. Emanuel Tanay's article on "Psychiatric Aspects of Homicide Prevention" (January 1972 issue) with great interest. I share with him a grave concern about the lack of a sound theoretical framework and of useful scientific models in the area of homicidal behavior that would enable us to enhance our understanding of the subject by more meaningful research and begin to establish and apply the science of homicide prevention on a broad scale. I think his conceptualizations and conclusions go a long way toward realizing these goals and throwing into sharp focus issues that scientists, legislators, and other thinkers cannot continue to ignore.

I am a bit disturbed about the nosology Dr. Tanay introduced because I feel it fails to include a large group of homicidal offenders who kill without premeditation. I have had a chance to examine this group clinically and others have written about those individuals whose personalities are so primitive and so devoid of developed, internalized structures and controls that they are particularly liable to act out ego-syntonicly, if you will, in a direct aggressive fashion, without much ego disruption, and certainly without the temporary collapse or flooding of a strong superego that never was. Many of these individuals are lower-class men who have been socialized to direct aggression outward. The superego is underdeveloped and values that oppose violence are not internalized. Growing up in an environment where severe physical punishment and even brutal aggression is commonplace, the child

may turn all of his energies toward avoiding the punishment but will not incorporate parental standards or prohibitions into his personality structure. "He may grow up thinking that guilt is a matter of getting caught, that all restraints come from outside, that rules should be disregarded if possible and fought if necessary, and that anger and aggression are things that go on between people rather than within them. Such a person might commit murder without remorse and for reasons that may appear trivial to others" (1).

These homicides are not the ultimate in planning and organization but, rather, the random and senseless explosive discharges of the moment that seem to be with us increasingly frequently. These individuals apparently have not internalized values but have predominantly resorted to "identification with the aggressor." For the sake of completeness and scientific validity, I would suggest the inclusion of this group of offenders in Dr. Tanay's schema either as an important subcategory of the ego-syntonic group or as a fourth category, the "Violent Subculture," composed of individuals with primitive personality structures and controls who learn (for I believe modes of aggression are learned) throughout their development in the milieu in which they live and grow to resort readily and easily to physical aggression in preference to other alternatives.

The reference is:

1. Wolfgang ME: Who kills them. *Psychology Today* 3(5):54-56, 72, 74-75, 1969

ROBERT L. GOLDSTEIN, M.D.
New York, N.Y.

Dr. Tanay Replies

SIR: I welcomed the letter from Dr. Bates since interest in homicide as a phenomenon is so infrequent among psychiatrists. His point about homicidal behavior in the military being an example of ego-syntonic homicide is well taken. It was merely the limitation of space that did not allow for specific elaboration of this issue. The soldier, the criminal, and the policeman have one thing in common: Their homicidal behavior is ego-syntonic.

I furthermore fully agree that alcohol plays a major role in initiating the altered state of consciousness and have demonstrated this in a previous publication (1). I do not agree with Dr. Bates that there is a demonstrated relationship between the occurrence of ego-syntonic homicide and the incidence of ego-dystonic homicide, which he seems to imply by his reference to the uniform as a license to "murder almost at will."

Dr. Goldstein's criticism of my paper is well jus-

tified. The examples cited by Dr. Goldstein are best classified as a subcategory of the ego-syntonic homicide, as he suggests. Behavior consistent with the values of a group to which one belongs is frequently, although not necessarily, ego-syntonic. Freud touched upon the conflict between two ego ideals arising out of membership in two different groups. He wrote in a letter to Ferenczi in 1918: "It is a question of a conflict between two ego ideals, the customary one and the one the war has compelled the person to build. The latter is concerned with relations to new objects (superior officers and comrades) and so is equivalent to the cathexis of an object; it might be called the choice of object not consonant with the ego" (2, p. 252). Freud returned to the same theme in a letter written to Jones one year later: "Now in the case of war, there is the conflict between the habitual and the fresh warlike ideal. The first is subjugated, but when the 'shell' arrives this older ego understands that it may be killed by the ways of the Alter Ego" (2, p. 254).

A great deal of violence, including homicide, is committed in compliance with a warlike ego ideal and is experienced at the time as ego-syntonic. With a change in the environmental setting, the same behavior becomes ego-dystonic and frequently leads to depression. I have encountered policemen who proudly kill in the line of duty only to be profoundly depressed later on. One of them committed suicide as a result of it. The same frequently applies to the members of the so-called "Violent Subculture," who rarely are able to escape identification with the prevailing ideals of humanity that taking human life is forbidden.

Sir James Frazer described a category of tabooed persons, namely, that of man-slayers, warriors who have killed an enemy and, therefore, must be purified (3).

A group or a society might approve of or overglorify certain killings. The individual, however, rarely, if ever, can kill a human being without some degree of guilt. Viet Nam veterans who have killed civilians in an ego-syntonic state frequently, in retrospect, experience their behavior as ego-dystonic. I have yet to find a killer who did not show some degree of guilt.

The references are:

1. Tanay E: Psychiatric study of homicide. *Amer J Psychiat* 125:1252-1258, 1969
2. Jones E: *The Life and Work of Sigmund Freud*, vol 2. New York, Basic Books, 1955
3. Frazer J: *The Golden Bough: A Study of Magic and Religion*. London, MacMillan & Co, 1950

EMANUEL TANAY, M.D.
Detroit, Mich.

Psychoanalysis: Out in the Cold?

SIR: Regarding the Special Section on "Residency Training" in general and Editor's Notebook in particular (March 1972 issue), I think it should be made clear that whereas there is no doubt a shift in emphasis in psychiatric training toward distributing our knowledge and care to a wider segment of the population as well as an increasing awareness of complex biological and social problems, there has been a simultaneous denigration of our knowledge of the individual and his psychology, specifically, either an absence of interest in or an outright hostility toward psychoanalysis. Whether this is justified or not is not the question, for it seems to be predictable. Indeed, some of us psychiatrists who remain interested in psychoanalysis despite claims of its obsolescence (1) wonder why the *Journal* rarely makes mention of it. Perhaps psychiatry has severed its ties, or perhaps psychiatry has never been tied to psychoanalysis. In any case, from the tone of the editors, it would seem as though we have discovered something new and better to replace psychoanalysis, or it was never understood and accepted as something worthwhile in the first place.

The reference is:

1. Shaw D: Freud's couch giving way to "now" therapy. *Los Angeles Times*, Feb 13, 1972

HARVEY D. LOMAS, M.D.
Los Angeles, Calif.

Editor's Note: Neither the Association nor the *Journal* has severed its ties with psychoanalysis, which we consider an essential part of psychiatry. However, the *Journal* can only select from among the articles submitted to it. There is no embargo on psychoanalytic articles; they are apparently, for the most part, going to psychoanalytic journals.

Effects of Posture on Thinking

SIR: Can you tell me if there have been studies on the physiological effects of posture on cerebration? Was it a coincidence that Freud used the reclining, supine position of the couch for free association? The fantasy effect of cloud watching in the supine position suggests a similar looseness in thought control, passivity. The choice of a sitting position, i.e., that of the statue "The Thinker," under whom one could place a commode, suggests controlled thought or aggression.

If the thinking processes of the brain are so sensitive to increased fluid retention as to account for the periodic changes in thought and behavior of "premenstrual tension," what effect on cerebration

does posture (i.e., the force of gravity) have on the vertical, as compared to the horizontal, position when one is either awake or asleep? Have there been any sleep studies done that compare sleep and dreaming when one is supine, prone, or lying in a position with the dominate side of the brain either up or down? Have there been any studies made with the body in Trendelenburg?

W.V. HEMPEL, M.D.
Alton, Ill.

Sexual Behavior: Significant Changes

SIR: In his editorial "Human Sexuality" (April 1972 issue) Dr. Daniel Offer expressed the need for augmented research in the many facets of human sexual behavior. I agree wholeheartedly and hope that his suggestions will be taken up by researchers in the behavioral sciences in this country and elsewhere. At the same time, I would like to take issue with his view of the nature of the "sexual revolution."

Dr. Offer stated that "findings from recent studies . . . have revealed little change in sexual behavior during the past two decades" despite the greater openness and candor with which society discusses human sexuality. I believe, to the contrary, that there has been a significant change in sexual behavior. The recent report of the Commission on Population Growth and the American Future (1) cited a study of a representative sample of unmarried women. It pointed out that 44 percent of the unmarried 19-year-old women had had premarital sexual intercourse. In contrast, Kinsey and associates (2) found that only 20 percent of unmarried women age 20 had had premarital coitus. Similarly, studies by Christenson and Gregg (3) have shown an increase in premarital coitus (between a sample studied in 1958 and another sample studied in 1968) among unmarried women from three different backgrounds: Mormon, Midwestern, and Danish.

In defense of his argument that no significant changes in sexual behavior have occurred, Offer cited the unpublished studies of Simon, Gagnon, and Carns. Unfortunately for his argument, these workers now feel that there *has* been an increase in premarital coitus among unmarried college women, although when the data are corrected for the age of marriage, the increase is less striking. This is also borne out by a number of other published and unpublished studies of college women.

While there have been more profound changes in attitudes than in behavior, there has, nevertheless, also been a significant change in behavior. This should serve only to strengthen Offer's persuasive arguments for additional research into the nature of the changes and their implications.

The references are:

1. Commission on Population Growth and the American Future: Report of the Commission on Population Growth and the American Future. Washington, DC, US Government Printing Office, 1972
2. Kinsey AC, Pomeroy WB, Martin CE, et al: Sexual Behavior in the Human Female. Philadelphia, WB Saunders, 1953, p 286
3. Christenson HT, Gregg CF: Changing sex norms in America and Scandinavia. *Journal of Marriage and the Family* 32:616-627, 1970

HAROLD I. LIEF, M.D.
Philadelphia, Pa.

BOOK REVIEWS

NEW HORIZON FOR PSYCHOTHERAPY: AUTONOMY AS A PROFESSION. Edited by *Robert R. Holt, Ph.D.* New York: International Universities Press, 1971, 411 pp., \$15.

This is a most important book. It deals with the planning and structuring of mental health services, particularly psychotherapy. Such plans will have substantial effect on the future of the psychiatric profession. In the last two decades it has become abundantly clear that mental health needs could not be met by the existing cadres of professionals, either inside or outside a hospital. Inevitably, as our medical resources proved to be insufficient and ineffective, nonmedical professionals whose areas of concern are with the mentally disabled have moved in to fill these needs. The book deals with this question and makes a convincing presentation of the feasibility and necessity for developing a new profession of psychotherapy.

Dr. Robert Holt has done an excellent job of editing and summarizing the papers that were presented at a conference held in 1963 to explore this question. He not only ties the various contributions into an integrated volume, but also presents, in a masterful way, the problem and an appraisal of the various proposals offered. This section can be read by itself and makes this book a necessary addition to the libraries of all social scientists concerned with human services.

There was general agreement among the participants at the conference that full medical training is not essential for the practice of psychotherapy, but that some healing orientation is essential. The questions of how, where, and when such training would take place can be resolved once the concept of such a new profession is accepted and a group of interested and energetic interdisciplinary educators join to achieve that purpose. The conference participants agreed that the need is present and that such a project can be pursued. The master architect, Lawrence Kubie, proposed a model that was the focus of the conference.

This issue seems not to be debatable any longer, and we should proceed to inaugurate several such programs. However, there are still questions to be answered. What is the definition and scope of psychotherapy? What are its boundaries in theoretical, legal, and practical terms? Does it differ from psychoanalysis, guidance counseling, pastoral counseling, and a host of other interventions?

Dr. Holt and the contributors to this volume maintain that there are valid distinctions between psychotherapy and psychoanalysis which are taken for granted. However, the definitions are so loose

and vague that they are operationally useless. In fact, these individuals also make distinctions within psychoanalysis, such as psychoanalytic psychotherapy and intensive psychotherapy (viz., on page 230 Dr. Rubinfine distinguishes "some form of expressive intensive psychotherapy not necessarily called classical psychoanalysis"). Such distinctions imply varying degrees of intensity and depth of movement, conveying the notion that some are more basic and causally directed while others are more superficial and symptom oriented.

Those distinctions create a hierarchy of treatment techniques ranging from the most basic (more curative) to the least intensive (only supportive). This hierarchy is transferred to the practitioners so that the psychoanalyst is viewed as causally oriented and therefore potentially curative, while the psychotherapist is viewed as being essentially engaged in holding procedures of reassurance and support. Dr. Holt unfortunately maintains these distinctions, singling out psychoanalysis as if it were sacrosanct and impregnable and the standard against which all forms of psychodynamic training should be modeled and compared.

This point of view is unfortunate and may actually be the most obstructive issue in developing a new profession. A variety of modalities and therapeutic techniques may be used without imposing an aristocracy on a particular technique or practitioner. Some techniques require additional training without necessarily implying greater integrity or healing capacity. Unfortunately, this view is widespread among the organizers and planners of this new profession.

The conference participants agreed that psychodynamic principles for understanding human behavior must be part of such a training program. However, the supporting theoretical structures, such as libido and instinct theory, and the therapeutic techniques that are derived from these hypotheses must be taught only as another theory of personality along with the diversity of views regarding what constitutes the basis for human development and functioning. Traditional psychoanalytic views are not more valid or sacrosanct, even though they were the revolutionary forerunners of all psychodynamic theory. Psychoanalysis is not a higher or deeper form of therapy. A psychoanalyst represents a highly trained psychotherapist. Psychotherapy should be the overall umbrella under which a large number of techniques is applied to alter behavior and modify character structure.

It might be better if the term psychoanalyst were dropped completely in favor of "psychotherapist," even though psychoanalysis would remain as a

name for the enormous contribution of such theorists and therapists. There will be good and bad therapists, intuitive and introspective ones, who use the tools of free association, dream analysis, and other devices to illuminate the out-of-awareness mental states. Some will be very effective and skillful and others ineffective and clumsy. However, there should not be a hierarchy of professional status ranging from the psychoanalyst to the mental health worker, except in terms of training, experience, and competence and not in the particular techniques they employ. Different problems require different prescriptions, but all should use healers from the same pool of professionals.

Consequently, we should plan for the ultimate demise of psychoanalytic institutes as training centers if we conceive of this new profession coming into being. Some students in psychotherapy training may wish to learn the intricacies of classical psychoanalysis and apply it to research or other purposes. Provision should be made for this track. The long, detailed, and intensive relationship in a dyad can still be the source of tremendous understanding of the psychology of man and should be supported and encouraged. But I believe that operationally psychoanalytic therapy is not essentially different from any other form of psychotherapy except for the strict application of certain technical principles. While the application of these principles has produced many significant understandings of man, there is no evidence that psychoanalysis is the only or the best way to achieve such results.

A new profession should use these insights without establishing first- or second-class practitioners, depending upon the technique they employ. As such, they could make a gigantic leap toward the scientific exploration of the therapeutic process without prejudice and preconceptions based on status and power. Such a profession would be most effective in overcoming the quackery and excesses in the healing profession and would be a growing source of supply of practitioners.

LEON SALZMAN, M.D.
Bronx, N. Y.

BIOCHEMISTRY, SCHIZOPHRENIAS, AND AFFECTIVE ILLNESSES. Edited by *Harold E. Himwich, M.D.* Baltimore: Williams & Wilkins Co., 1970, 469 pp., \$18.75.

Interest in the neurochemical bases of behavior has been growing rapidly, with the most marked development resulting from the influx of pharmacologists, endocrinologists, and even molecular biologists into the area of the neurosciences. The clinical implications of this basic science work have only begun to be felt, and they have generally been restricted to the natural "bridge" areas such as psychopharmacology. Studies using psychoac-

tive drugs and precursors of brain neurotransmitters such as L-dopa have suggested that man's mood, motor activity, and memory are alterable in an understandable fashion, with the changes paralleling the effects of such drugs on animals.

Despite this increased information, there is still only sparse evidence that any of the mood, motor, or cognitive changes which occur in the major psychoses are the direct result of altered neurochemistry. Hypotheses abound and models are being modified, but it remains to be seen whether there will emerge a more definite link between biochemistry and the psychoses than the uncertain connection represented by the commas in the title of this book.

Some aspects of the present state of knowledge are examined in 15 reviews of biological studies and hypotheses relevant to schizophrenia and the affective disorders. Biogenic amine-related research receives the most intensive coverage (six chapters). Investigations of the immunoglobulin question in schizophrenia and of steroid, electrolyte, and carbohydrate changes in the psychoses are more briefly reviewed. There are also one-chapter reviews of psychotomimetic agents, the periodic psychoses, and psychoses associated with other illnesses.

The reviews are generally up-to-date, well referenced, and compiled by researchers closely identified with their subjects. Although a few chapters take the form of an apologia for a particular point of view, most of the reviews are well-balanced blends of the individual's research examined in the perspective of other studies. However, the psychodynamically inclined or even eclectic reader should be aware that little heed is paid to any issues beyond the biological. There are no attempts toward integration of the biological events with psychosocial or other phenomena in the psychoses.

The book's main value is in bringing together current and dominant research approaches in the biology of psychotic behavior. While several of the reviews are simply shortened versions of previously published reports, their availability in this volume in juxtaposition with other data is a convenience to the reader interested in comparing the various theories. I recommend the book as a reasonable appraisal of the strengths and weaknesses of recent studies in biological psychiatry.

DENNIS L. MURPHY, M.D.
Bethesda, Md.

YOUTH AND DISSENT: THE RISE OF A NEW OPPOSITION. By *Kenneth Keniston, Ph.D.* New York: Harcourt Brace Jovanovich, 1971, 403 pp., \$9.95.

The volume under review consists of 19 separate articles written by Dr. Keniston between 1960 and 1971. Each article is introduced by the author in a short paragraph in which he shares with the reader

what he thinks now (in 1971) of what he has written previously. The book contains articles on alienated youth, radical youth, drug users, dropouts, the functions of the university, American society, and the counter culture, among others.

In my opinion the best article is the first, titled "Youth as a Stage of Life." In it Keniston proposes that "we are witnessing today the emergence, on a mass scale, of a previously unrecognized stage of life, a stage that intervenes between adolescence and adulthood" (p. 7). Keniston believes that this new stage is responsible for the college student's questioning of his relationship between self and society. It is a psychological stage in which the young adult decides on his more lasting commitments. The idea is novel and opens new vistas for understanding our youth.

Keniston does not explain in this book the tasks, conflicts, and potential psychopathology of this new stage. Radical youth is not discussed in historical context, summarizing the available literature and pointing to the promise and the pitfalls of the "rise of the new opposition." If the reader has any such expectations he will be disappointed. What he will find instead is a subjective (not clinical) description of dissident youth, a description full of clichés and the creation of straw men (e.g., quoting Martha Mitchell as an "authority" on p. 353).

I missed the clinical richness found in Keniston's first book, *The Uncommitted* (1). In *Youth and Dissent* young radicals, on the whole, are seen as wonderful people who are idealistic, strong, and mentally healthy and who have the potential for saving us all. It seems that Keniston was not able to develop the necessary distance from his subjects so that he could observe both their strengths and their weaknesses. At times one gets the impression that although Keniston pays lip service to psychopathology, he really does not investigate the possibility that psychopathology may exist in the majority of his subjects (who include drug users, dropouts, and alienated youth). Many, if not most, of their problems are blamed on "the system." The book reflects exactly what Keniston states he wanted it to reflect: his sympathy and identification with the opposition (p. xi).

Finally, the book has no references or index, and there are many theories and observations that are repeated, unchanged, in three or four different articles. The 19 different pieces do not provide an integrated or coherent statement on dissident youth. As a scholarly treatise, a clinical study, or psychosocial observation, the book fails.

The reference is:

1. Keniston K: *The Uncommitted: Alienated Youth in American Society*. New York, Harcourt, Brace & World, 1965

DANIEL OFFER, M.D.
Chicago, Ill.

ABORTION AND THE UNWANTED CHILD. By the California Committee on Therapeutic Abortion, edited by Carl Reiterman. New York: Springer Publishing Co., 1971, 175 pp., \$7.50.

Abortion and the Unwanted Child provides a summary account in the form of a series of papers by distinguished contributors against anti-abortion laws, supported by statistical and sociological facts, together with compelling psychological considerations. Limitation of space permits me to briefly comment on only some of the contributions.

Professor Garrett Hardin presents arguments in favor of abortion for the sake of the child, and he examines motivations that lead a woman into pregnancy. His stress is upon conscious (often calculating) factors, rather than on the unconscious ones, which are not easy to determine upon a cursory inspection of the given case. A question raised by implication in Professor Hardin's paper, as well as in some of the others, is the extent to which there is any connection between the sexual drive and the wish to have a child. (We would certainly doubt if it were conscious.)

The compelling point that Professor Hardin raises is whether a woman has the ability to adequately mother a child. This will depend primarily upon her emotional state, i.e., in a word, whether she possesses what I would term "maternal endowment." It may be defined in many ways, but perhaps best by Anna Freud and the child analysts, in terms of a mother's ability to effect a positive object-relationship with her child. One conclusion from this paper is that if bearing children were based upon emotional adequacy, there would be no overpopulation problem.

Dr. Edmund Overstreet, of the Department of Obstetrics and Gynecology of the University of California Medical Center, writes on "California's Abortion Law—A Second Look." This most informative article deals with the consequences and implications of California's abortion law. The point that Dr. Overstreet emphasizes is that although California's recent Therapeutic Abortion Act has resulted in a greater number of abortions, it has also resulted in a marked decline in abortion-related maternal deaths. This is due to a decrease in criminal abortions performed under conditions that result in infection and complications.

In her article on the "Grounds for Legal Challenge" of anti-abortion laws, Norma Zarky of the Beverly Hills Bar Association questions the legality of state abortion statutes for their failure to accede to a woman's right to determine the number of her offspring. Ms. Zarky believes that anti-abortion laws may be challenged on the grounds that they restrict a physician from "the proper practice of medicine." She holds that there is no valid argument that any state interest would be compromised if restrictions upon abortion were lifted.

Dr. Sally Provence of the Yale Child Study Center cites vignettes from cases of unwanted children. If a generalization can be made from this material, it may be said that an unwanted pregnancy casts doubts upon the mother's ability to relate to the prospective child. Dr. Provence is an experienced child psychiatrist who has been confronted for a number of years with a wealth of data on emotionally disturbed children.

Dr. E. James Lieberman, a psychiatrist in the field of public health, documents the difficulties of child rearing and the neglect attendant upon that task. He advocates "informed consent" as a prerequisite for parenthood, which means that "couples be told whatever is known about their chances to produce and rear a healthy child." I do not believe, however, that "the more education, the better" is an adequate prescription for parenthood. As I said in an article published in this journal (1), the concept of planned parenthood is confusing, if not meaningless. It makes more sense to speak about the "planned conditions" for parenthood. This concept implies that a woman is emotionally able to effect a positive relationship with her child, which is not a matter of education but rather of emotional maturity.

I think that Dr. Lieberman's remarks on the extent of a pregnant woman's ambivalence are well taken. The degree of her ambivalence may serve as a criterion for a decision in regard to an abortion; and if it is marked, too much may be left to chance in regard to her fitness for motherhood.

Former Senator Maurine Neuberger quotes the commonsense remark of an obstetrician, who declared that he never performed an abortion that did not benefit the woman and went on to say that he didn't believe an abortion makes a woman neurotic, but that an unwanted pregnancy does. To be more accurate we should say that an unwanted pregnancy may be symptomatic of a neurosis, but never causal. Ms. Neuberger concludes with a statement that might well commend her for election if she should decide to run for office again: "What we want is the right for a woman to have an abortion on request; the right to have a life in which she can bear *wanted* children. In the last analysis it is the right of a woman to decide, and is a private matter between herself and her doctor. Let's not have any more committees!"

The last paper is a short conclusion by the editor on "Unwanted Children." The crux of the problem in regard to abortion is that bearing a child should be a woman's *free choice*, not subject to inner compulsion or to external coercion.

There are a few obvious conclusions to be drawn from this collection of short papers. The salient points in favor of repeal of anti-abortion laws are: 1) that they do not take cognizance of whether a child is wanted; 2) that abortion is one of the necessary measures to be taken at present for effective

population control; and 3) that abortion may at times be the last resort or sole means of protecting the physical and mental well-being of the woman. Finally, I would like to make an appeal that I believe the contributors to this book would concur with: that the future *quality* of our species may depend upon enlightenment governing our attitude toward abortion.

The reference is:

1. Aarons ZA: Therapeutic abortion and the psychiatrist. *Amer J Psychiat* 124: 745-753, 1967

Z. ALEXANDER AARONS, M.D.
Walnut Creek, Calif.

FREUD, JUNG, AND OCCULTISM. By *Nandor Fodor*. New York: Lyle Stuart, 1972, 272 pp., \$7.95.

This book provokes mixed reactions. On the one hand, Dr. Fodor's brisk summary of the views of Freud and Jung on the occult proves fascinating reading. We are indebted to the late author, a psychoanalyst known for his interest in birth trauma and in parapsychology, for a handy guide to the thinking of Freud and Jung on such disparate and engaging subjects as premonitions, poltergeists, telepathy, life after death, and the existence of spirits. The author's style is provocative, and the broad overview he provides makes for swift reading and easy acquaintance with an obscure subject matter.

On the other hand, the author's journalistic approach to Jung and Freud (chapter titles include "Traitor—to Whom?" and "The First Time Jung Died") exposes his book to the limitations of that method: superficiality, inaccuracy, and incomplete presentation of ideas. Footnote references are contained within the text, which makes them hard to find if the reader wants to go back and look something up. Very often Dr. Fodor's reactions are made more important than what elicits them. One comes away with vivid impressions of Dr. Fodor's feelings about Freud's and Jung's ideas of psychic participation, for example, but only hazy notions of what Freud or Jung said. It is clear that Dr. Fodor was a lively, intuitive, genial man who was caught up with supernormal phenomena and was unwilling to foreclose debate on their meaning. He was not necessarily a trustworthy reporter of other men's attitudes, however.

Dr. Fodor clearly favored Freud's cool-headed skepticism toward the occult over Jung's explosive contact with the world of the uncanny. Yet Dr. Fodor devotes more pages to Jung's experiences and painstaking research into the occult than he does to Freud's work in the field, thus implying that of the two giants Jung has more to teach us about the world of vision, apparition, and life beyond the space-time dimensions.

Dr. Fodor leaves us with the impression that Freud feared the world of parapsychology, that he was curious about it but preferred finally to translate its irrational phenomena into the more manageable terms of rational explanation. Thus telepathic phenomena could be explained as delusory memory—or the confusion of fantasy with reality (p. 132). Premonitions of disaster could be explained as masked expressions of envy (p. 62) or of aggression (p. 67). Even though Dr. Fodor indulges in wild distortions of some of Jung's views (for example, on *The Tibetan Book of the Dead* [p. 159]), he does present Jung as a man courageously trying to examine the psychic meaning of the occult.

In 1919 Jung viewed the manifestation of spirits as unconscious autonomous complexes that are exteriorized through projection. After almost 30 years of observing the human psyche, however, Jung concluded in 1947 that the psychological approach did not do full justice to parapsychological phenomena. He did not endorse spiritualist beliefs, but he left as an open question the existence and nature of a reality that exists beyond the psyche.

Although Freud was made uncomfortable by so-called occult phenomena, like Jung (and William James before him) he could not simply dismiss these manifestations. Dr. Fodor's book, for all its limitations, serves the useful purpose of making one reexamine what the founding fathers of depth psychology had to say about the important subject of parapsychology. The book includes an excellent appendix by Aniela Jaffe, Jung's longtime secretary and disciple.

ANN BELFORD ULANOV, TH.D.
New York, N.Y.

COUNSELING PARENTS OF THE ILL AND THE HANDICAPPED. Edited by Robert L. Noland. Springfield, Ill.: Charles C Thomas, 1971, 599 pp., \$15.75.

Time magazine once quoted operatic star Beverly Sills, who has a deaf daughter and a mentally retarded son, as saying: "The first question you ask is a self-pitying 'Why me?' Then it changes to a much bigger 'Why them?' It makes a whole difference in your attitude" (1). Readers are not told whether Miss Sills achieved this admirable transformation through her own searching and growth or through professional help. We do know, however, that most parents of handicapped children need, often desperately, the help of a knowledgeable and trained person.

Dr. Noland has compiled and edited this book in order to provide a source for those in the helping professions who will be called on in these situations. The book, which consists of 55 papers drawn from 34 journals, covers such disabilities as mental retardation, epilepsy, cerebral palsy, speech

impairments (including stuttering and cleft palate), hearing and visual defects, cardiac, diabetic, hemophilic, and asthmatic handicaps, and severe and terminal illnesses such as leukemia. An opening section deals with counseling techniques and the value of group processes; a closing section deals with genetic counseling.

Dr. Noland is correct in emphasizing that the parents' attitudes are often as important as the child's, if not more so, in determining the outcome of treatment; that the crisis may jeopardize parental family adjustment; and that competent help implies that all relationships (child-parent, parent-parent, and parent-family) must be considered.

A collection of papers inevitably leads to an unevenness of quality and depth, hence this book ranges from brief and superficial generality to carefully designed clinical investigation. However, it satisfactorily covers the broad range of adaptations and maladaptations, guilt, resentment, denial, and a host of other reactions to the child's disability and illness. Dr. Noland's book provides a source of considerable practical wisdom and knowledge; it is most welcome.

The reference is:

1. Beverly Sills: the fastest voice alive. *Time*, November 22, 1971, pp 74-76

SAUL H. FISHER, M.D.
New York, N.Y.

THE SKYJACKER. By David G. Hubbard, M.D. New York: Macmillan Co., 1971, 262 pp., \$5.95.

Dr. Hubbard, a member of the American Psychiatric Association, has made an individual psychiatric study of a number of airplane hijackers. He finds that typically, they are sexually inadequate men who had violent, often alcoholic fathers, and mothers who were frequently religious zealots. In general, these hijackers were failures in life. Dr. Hubbard attaches much importance to the physiologic and psychologic components of the sense of balance, seeing infancy as a period of struggle against the forces of gravity, attaching importance to the primitive desire to be as free as birds, noticing that psychotic minds are often described as "unbalanced," and suggesting that the semicircular canals, which are important in keeping us in balance, may be physiologically disturbed among the airplane hijackers, or, as he prefers to call them, "skyjackers."

So many of the skyjackers were sexually inadequate that Dr. Hubbard thinks of the plane as a phallic symbol and notes how often stewardesses are the first target of the skyjacker, visualizing the whole experience as a kind of symbolic rape. He downgrades the political factor and the nominal quest for asylum. But since so many of his subjects

were failures, he sees the hijacking as "a reversal of the downward plunge of their lives."

Since hostility to the Establishment is one of the facts of modern life, the author visualizes a hijack attempt as an exciting form of anti-establishmentarianism as well as, in his words, "a re-enactment of the previous resolution of the Oedipus conflict crossing the hostile barrier between father and mother." He notes that passengers are generally passive during the excitement and attributes this not to fear of being injured, but to self-dramatization at being part of a history-making event, in addition to some satisfaction at seeing the forces of the Establishment getting their comeuppance.

The author finds a distinct chronologic relationship between news of space events (such as moon landings or sending satellites into orbit) and the frequency of skyjacking, and he recommends immediate return of skyjackers, their prompt hospitalization (for study), and broadcasting the fact that most plane hijackers are sexually inadequate and failures in life.

The presentation is interesting, and psychiatrists called on to examine skyjackers will find some thought-provoking pointers here. In the single case I handled, it was certainly true that I found a man who fitted the psychodynamic profile described by Dr. Hubbard. He was a failure in life, and his wife had left him. He threatened to disfigure the stewardess if she denied him access to the pilot. He was also a classic manic-depressive in a manic episode.

In jurisdictions that use the M'Naghten rule, a defendant with this condition probably does "know" that hijacking is wrong. In some of the federal courts, where the rule requires that defendants possess "substantial capacity to appreciate the criminality of their conduct," it can be said in clear conscience that such a person has some, but not "substantial" capacity and that he knows that the act is wrong, but that he does not "appreciate" it. Psychiatric study in an individual case should also address itself to the question of the defendant's competency to stand trial, to advise counsel, and to understand the trial procedure.

The book may be a bit too theoretical and, at times, preciously psychodynamic for most professional readers, but it is an unusual presentation of a troublesome problem well worth reading.

HENRY A. DAVIDSON, M.D.
East Orange, N.J.

BECOMING AN UNWED MOTHER: A SOCIOLOGICAL ACCOUNT. By *Prudence Mors Rains, Ph.D.* Chicago: Aldine-Atherton, 1971, 202 pp., \$6.95.

The problems of unwed pregnant females have long been a matter of professional concern because

of their wide-reaching moral, social, physical, and emotional impact on individuals and on the institutions of our society. This sociological account by Prudence Mors Rains of some of the many different aspects attached to becoming an unwed mother is an interesting contribution to the body of literature on this subject. The descriptive and phenomenological approach is presented in a clear and concise manner so that its value extends beyond its sociological format. Regardless of professional discipline, readers of this work should be able to apply some of the insights that emerge from the comments of these unwed pregnant females who are the subject of this study.

The substance of the book consists of a series of recorded statements and observations from two programs for young, unwed pregnant females: one, a well-staffed private residential maternity home located in a residential area of a large city in the East and serving a predominantly middle-class, white clientele, and the other, a small, minimally staffed, temporary "pilot" day school for unwed mothers located in the black ghetto of a large city in the Midwest and serving young black girls. Other portions of the book are devoted to concepts rooted in the ideology and semantics of the field of sociology. These sections contain many broad statements with assumptions of cause and effect without adequate verification or documentation.

However, the principal thrust of the book remains invested in the attitudes and interactions of the pregnant girls and the staffs that were serving them. It is here that the many dimensions of the problems emerge. The author devotes most of her comments to the impact of events on the pregnant girls. However, the content of the recorded material goes much beyond this in its reflection of the mores and attitudes of society toward the problem of the unwed pregnant female. The bias of both the community and of the professionals representing the community are recorded clearly across the pages of this book.

Several surprising and perhaps critical omissions rob this book of its full potential. The first is a failure to identify the factors that led these particular unwed pregnant females to choose motherhood rather than abortion or marriage, the only other alternatives proposed by the author. This failure limits and narrows the perspective of the research by oversimplifying the complex and multidetermined motivations leading unwed pregnant females toward motherhood.

The second omission is identified by the author, and her explanation reveals a strange and inadequately explained prejudice within her research, supposedly rooted in the scientific method. Both groups of unwed pregnant females were delivered of their children in medical facilities away from the described programs. All the recorded observations were made prior to or following this critical mo-

ment of pregnancy because Dr. Rains felt that any contact with the pregnant females at this time represented an intrusion on their privacy. All research of human behavior should be recognized as an intrusion on privacy. Such an awareness would result in more clearly defined research and perhaps less prejudicial reporting of observations. In this instance, this acknowledged omission challenges the scientific accuracy of the other observations on these unwed pregnant females.

SOL NICHTERN, M.D.
New York, N.Y.

HUMANISTIC PSYCHIATRY: FROM OPPRESSION TO CHOICE. By Roy D. Waldman, M.D. New Brunswick, N.J.: Rutgers University Press, 1971, 164 pp., \$6.

This is a slight volume, which makes one wonder whether existential works can be reviewed or only read. The book provides the reader with a number of impressions that are difficult to reduce to specifics, due in part to the author's failure to define existential terms even though these terms are crucial to the understanding of the book's contents.

For example, the word "Other," whether capitalized or not, seems to be used in various ways. A child is said to develop a sense of self-esteem from the attitude the "other" has toward him; and the oedipal situation is credited with providing the child with the awareness that no task may be accomplished without heed to the opinion of the "Other." The frequent reference to this term in the case history is of little relevance to the uninitiated reader, e.g., "... she has sown the seeds in the garden of the Other..." and "Unwilling to say no to the Other she accomplishes this intent through her dizziness."

The author feels that uses, ends, and meanings, rather than causes and mechanisms, are basic to the comprehension of individual and collective levels of conduct. Oppression, on the other hand, reflects the insecurity of man's life rather than an evil, instinctual nature. An instinct becomes, then, not an unalterable fact, but "a mere artifact of a particular human situation." And the oedipal event is refreshingly seen as a transitional phase during which the child is converted from a biological creature to a symbolic actor. Mental illness is defined as "... simply one of man's many choices by which he eschews the task of freedom, truth and responsibility. ..." This choice is, in turn, interpreted as being comprehensible only in view of the total life situation.

This brief work includes a clearly stated, well-written chapter on "The Self," as well as others on "Fundamentals of Existence," "Neurosis in Society and Man," "Existential Dimension," "Free-

dom and Humanistic Psychotherapy," "Community and Faith," and "Human Conduct: Medicine or Morality." All in all, the book is quite readable, which is unusual in literature on this subject.

JACKSON A. SMITH, M.D.
Maywood, Ill.

THE PSYCHODYNAMIC IMPLICATIONS OF THE PHYSIOLOGICAL STUDIES ON PSYCHOMIMETIC DRUGS. Edited by Leo Madow, M.D., and Laurence H. Snow, M.D. Springfield, Ill.: Charles C Thomas, 1971, 81 pp., \$7.75.

This volume contains the papers presented at a symposium at the Medical College of Pennsylvania. In the introduction Dr. Leo Madow points up the purpose of this book as an effort to provide an understanding of the basic psychological considerations for the burgeoning use of psychomimetic drugs and of the best therapeutic approach for the drug users. In the preface Dr. Snow comments succinctly, "We speak not of drug users but of drug abusers." He thus sets the stage for the five chapters, all written by well-qualified, experienced investigators and clinicians.

The chapters cover the psychological effects of psychomimetic agents, the assessment of LSD treatment efficacy, the marijuana question, and the psychodynamics of the drug experience and drug choice. Initially Dr. Sidney Cohen presents a most lucid, graphic picture of the LSD "good trip." Dr. Arnold Ludwig then points out that "the evidence for the efficiency of these agents is definitely inconclusive." Dr. Laurence Snow indicates a sanguine bias toward marijuana use, but offers inconsistent statements about untoward side effects of the drug.

Dr. Mortimer Ostow places emphasis upon the drug experiences resulting in primary process thinking and postulates that regression is facilitated through temporal lobe mechanisms.

In the final chapter Dr. William Frosch discusses the uniformity of individuals involved in drug abuse. They are orally demanding and have impaired object relations and problems of passivity and aggression. Dr. Frosch quotes Rado as saying, "Not the toxic agent, but the impulse to use it makes an addict of a given individual."

The editors and their contributors have achieved their goal of providing considerable understanding of basic emotional factors involved in the widespread use of psychomimetic drugs. They have also provided excellent descriptions of the phenomenology of hallucinogenic drug use. However, they offer little that is specifically directed toward more effective therapy of drug dependence.

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This Month's Reviewers

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Books Received

The following books have been received; the courtesy of the sender is acknowledged by this listing. Books of particular interest to the readers of this journal will be reviewed as space permits.

GRUPPENDYNAMIK DER KREATIVITÄT. By *Günter Ammon*. Berlin: Pinel-Publikationen, 1972, 122 pp., DM 8, 80 (paper).

PASSAGES: A GUIDE FOR PILGRIMS OF THE MIND. By *Marianne S. Andersen* and *Louis M. Savary*. New York: Harper & Row, 1972, 221 pp., \$4.95 (paper).

SCHIZOPHRENIA: A PSYCHOPHARMACOLOGICAL APPROACH. By *Thomas A. Ban, M.D.* Springfield, Ill.: Charles C Thomas, 1972, 122 pp., \$12.75.

HALFWAY THROUGH THE TUNNEL. By *Barry R. Berkey, M.D.* New York: Philosophical Library, 1972, 215 pp., \$7.50.

PERSONALITY CHANGES IN AGING: A LONGITUDINAL STUDY OF COMMUNITY RESIDENTS. By *Joseph H. Britton* and *Jean O. Britton*. New York: Springer Publishing Co., 1972, 213 pp., \$8.50.

BEHAVIOR AND ADAPTATION IN LATE LIFE (second printing). Edited by *Ewald W. Busse, M.D.*, and *Eric Pfeiffer, M.D.* Boston: Little, Brown and Co., 1969, 383 pp., no price listed (paper).

A SCREAM AWAY FROM HAPPINESS. By *Daniel Casriel, M.D.* New York: Grosset & Dunlap, 1972, 300 pp., \$6.95.

RELIGION MAY BE HAZARDOUS TO YOUR HEALTH. By *Eli S. Chesen, M.D.* New York: Peter H. Wyden, 1972, 139 pp., \$4.95.

WOMEN AND MADNESS. By *Phyllis Chesler, Ph.D.* Garden City, N.Y.: Doubleday & Co., 1972, 353 pp., \$8.95.

PSYCHOLOGICAL MEDICINE: AN INTRODUCTION TO PSYCHIATRY, 7th ed. By *Desmond Curran, C.B.E., M.B., D.P.M.*, *Maurice Partridge, D.M., D.P.M.*, and *Peter Storey, M.D., D.P.M.* Baltimore: Williams & Wilkins Co., 1972, 428 pp., \$11.50.

METAMORPHOSIS OF A CRIMINAL. By *Ed Edwards*. New York: Hart Publishing Co., 1972, 438 pp., \$5.95.

THE LEAVES OF SPRING: A STUDY IN THE DIALECTICS OF MADNESS. By *Aaron Esterson*. Baltimore: Penguin Books, 1972, 302 pp., \$1.25 (paper).

REFORM AT OSAWATOMIE STATE HOSPITAL: TREATMENT OF THE MENTALLY ILL, 1866-1970. By *Lowell*

Gish. Lawrence: University Press of Kansas, 1972, 276 pp., \$9.50.

THE VOICE AND ITS DISORDERS, 3rd ed. By *Margaret C.L. Greene*. Philadelphia: J.B. Lippincott Co., 1972, 445 pp., \$19.

CONCEPTUAL INDEX FOR PSYCHOANALYTIC TECHNIQUE AND TRAINING, VOL. 1: CODE; VOL. 2: ABREACTION TO EDUCATION AND TRAINING. Compiled and edited by *Henry Harper Hart, M.D.* Croton-on-Hudson, N.Y.: North River Press, 1972, 460 pp., \$240 (five-volume set).

PSYCHOSURGERY. Proceedings of the Second International Conference on Psychosurgery held in Copenhagen, Denmark. Edited by *Edward Hitchcock, Lauri Laitinen, M.D.*, and *Kjeld Vaernet, M.D.* Springfield, Ill.: Charles C Thomas, 1972, 424 pp., \$24.75.

PSYCHOTHERAPY. By *Donald J. Holmes, M.D.* Boston: Little, Brown and Co., 1972, 1,042 pp., \$15.

BEHAVIOUR MODIFICATION IN SOCIAL WORK. By *Derek Jehu, Pauline Hardiker, Margaret Yelloly*, and *Martin Shaw*. New York: John Wiley & Sons, 1972, 190 pp., \$10.95.

TRANSCULTURAL RESEARCH IN MENTAL HEALTH, VOL. II OF MENTAL HEALTH RESEARCH IN ASIA AND THE PACIFIC. Edited by *William P. Lebra*. Honolulu: University Press of Hawaii, 1972, 423 pp., \$14.

MYTHOLOGY: SELECTED READINGS. Edited by *Pierre Maranda*. Baltimore: Penguin Books, 1972, 309 pp., \$3.95 (paper).

POWER AND INNOCENCE: A SEARCH FOR THE SOURCES OF VIOLENCE. By *Rollo May*. New York: W.W. Norton & Co., 1972, 271 pp., \$7.95.

A SYSTEM OF MEDICAL HYPNOSIS (reissue). By *Ainslie Meares, M.D., D.P.M.* New York: Julian Press, 1972, 474 pp., \$15.

CLINICAL NEUROPSYCHOLOGY. By *Edgar Miller*. Baltimore: Penguin Books, 1972, 146 pp., \$2.85 (paper).

THE FOURTH FLIGHT OF THE STARFIRE. By *Edwin Mumford*. Jericho, N.Y.: Exposition Press, 1972, 48 pp., \$4.

SHAME AND GUILT: A PSYCHOANALYTIC AND A CULTURAL STUDY (1953). By *Gerhart Piers* and *Milton B. Singer*. New York: W.W. Norton & Co., 108 pp., \$1.95 (paper).

PLAY AND DEVELOPMENT: A SYMPOSIUM. Edited by

Maria W. Piers. New York: W.W. Norton & Co., 1972, 176 pp., \$5.95.

THE ADOLESCENT GAP: RESEARCH FINDINGS ON DRUG USING AND NON-DRUG USING TEENS. By *Edward M. Scott, Ph.D.* Springfield, Ill.: Charles C Thomas, 1972, 125 pp., \$6.95.

PERSPECTIVES IN ZOOSEMIOTICS. By *Thomas A. Sebeok.* The Hague: Mouton & Co., 1972, 181 pp., 32 DG (paper).

DEATH AND THE COLLEGE STUDENT: A COLLECTION OF BRIEF ESSAYS ON DEATH AND SUICIDE BY HARVARD YOUTH. Edited by *Edwin S. Shneidman, Ph.D.* New York: Behavioral Publications, 1972, 207 pp., \$4.95 (paper).

"IT'S SO GOOD, DON'T EVEN TRY IT ONCE": HEROIN IN PERSPECTIVE. Edited by *David E. Smith, M.D.,* and *George R. Gay, M.D.* Englewood Cliffs, N.J.: Prentice-Hall, 1972, 208 pp., \$5.95.

U.S. HEALTH CARE: WHAT'S WRONG AND WHAT'S RIGHT. By *Stephen P. Strickland.* New York: Universe Books, 1972, 127 pp., \$2.45 (paper).

DRUG USE AND SOCIAL POLICY. Edited by *Jackwell Susman.* New York: AMS Press, 1972, 595 pp., \$8.95 (paper).

PSYCHOPHYSIOLOGICAL STUDIES OF EMOTION AND MENTAL DISORDERS. By *Nozomi Suwa, M.D.,* and *Itaru Yamashita, M.D.* Sapporo, Japan: Hokkaido University School of Medicine, 1972, 226 pp., no price listed.

THE NATURAL DEPTH IN MAN. By *Wilson Van Dusen.* New York: Harper & Row, 1972, 197 pp., \$5.95.

SUICIDE AND ATTEMPTED SUICIDE. Edited by *Jan Waldenström, Tage Larsson,* and *Nils Ljungstedt.* Stockholm: Nordiska Bokhandelns Förlag, 1972, 320 pp., \$11.20.

ON DYING AND DENYING: A PSYCHIATRIC STUDY OF TERMINALITY. By *Avery D. Weisman, M.D.* New York: Behavioral Publications, 1972, 237 pp., \$9.95.

DRUG ABUSE AND DRUG COUNSELING: A CASE APPROACH. By *Thomas Weisman.* Cleveland, Ohio: The Press of Case Western Reserve University, 1972, 186 pp., \$5.95 (paper).

PRACTICAL ASPECTS OF MENTAL HEALTH CONSULTATION. Edited by *Jack Zusman, M.D.,* and *David L. Davidson, M.D.* Springfield, Ill.: Charles C Thomas, 1972, 152 pp., \$6.75.

ANNUAL INDEX

Following is the comprehensive index for volume 129 of the *Journal*, covering all material from July 1972 through December 1972. (Volume 129 is a short volume consisting of only six months rather than 12. With the January 1973 issue, the *Journal* changes its volume year to coincide with the calendar year of 1973.)

The complete citation for each article in the author index is listed under the name of the first author; joint authors are listed alphabetically with a cross reference to the full citation.

Book reviews appear only in the subject index, under that heading, and are arranged alphabetically by the surname of the book's principal author or editor.

Abbreviations indicating entries other than regular articles, Special Section articles, and Brief Communications are: (Ed. N.), Editor's Notebook; (Ltrs. to Ed.), Letters to the Editor; (In Mem.), In Memoriam; and (Off. Act.), Official Actions.

Author Index

A

- Agras, W.S.: see Hersen, M., jt. au.
 Agulnik, P.L., DiMascio, A., and Moore, P.: Acute Brain Syndrome Associated with Lithium Therapy, 621-623, Nov. 1972.
 Allman, L.R., Taylor, H.A., and Nathan, P.E.: Group Drinking During Stress: Effects on Drinking Behavior, Affect, and Psychopathology, 669-678, Dec. 1972.
 Appleton, W.S.: The Importance of Psychiatrists' Telling Patients the Truth, 742-745, Dec. 1972.
 Arlow, J.A.: see Ostow, M., jt. au.

B

- Bach, P.B.: discussion of D.R. Bey, Jr., Change of Command in Combat: A Locus of Stress, 702, Dec. 1972.
 Bardoni, A.: see Stanton, M.D., jt. au.
 Barton, W.E.: Ewald William Busse, M.D., One Hundredth President, 1971-1972, 12-16, July 1972.
 Barton, W.E.: Report of the Medical Director (Off. Act.), 511-512, Oct. 1972.
 Bass, R.D., and Windle, C.: Continuity of Care: An Approach to Measurement, 196-201, Aug. 1972.
 Bassett, L.: see Hart, W.T., jt. au.
 Bates, G.M., Jr.: Homicidal Acts of War (Ltrs. to Ed.), 766, Dec. 1972.
 Baxter, J.A.: The Mini-Boards: Their Place in Psychiatric Training (Ltrs. to Ed.), 635, Nov. 1972.
 Beigler, J.S.: The 1971 Amendment of the Illinois Statute on Confidentiality: A New Development in Privilege Law, 311-315, Sept. 1972.
 Beiser, M.: The Lame Princess: A Study of the Remission of Psychiatric Symptoms Without Treatment, 257-262, Sept. 1972.
 Benedek, E.P.: Child Custody Laws: Their Psychiatric Implications, 326-328, Sept. 1972.
 Benschoter, R.: see Wittson, C.L., jt. au.
 Benson, S.G.: see Lipp, M.R., jt. au.
 Bergman, R.L.: reply to M.L. Wordsworth, Peyote Use: A Case Report (Ltrs. to Ed.), 96-97, July 1972.
 Bernard, V.W.: reply to L.H. Lipsius, Reaching Black Professionals (Ltrs. to Ed.), 631, Nov. 1972.
 Bey, D.R., Chapman, R.E., and Tornquist, K.L.: A Lithium Clinic, 468-470, Oct. 1972.

- Bey, D.R., Jr.: Change of Command in Combat: A Locus of Stress, 698-702, Dec. 1972.
 Bibb, R.C., and Guze, S.B.: Hysteria (Briquet's Syndrome) in a Psychiatric Hospital: The Significance of Secondary Depression, 224-228, Aug. 1972.
 Blachly, P.H.: discussion of C.L. Bowden and J.F. Maddux, Methadone Maintenance: Myth and Reality, 439-440, Oct. 1972.
 Bloch, H.S.: Experiences in Establishing School Consultation, 63-68, July 1972.
 Blumenthal, M.J.: see Ostow, M., jt. au.
 Bolman, W.M.: Community Control of the Community Mental Health Center: I. Introduction, 173-180, Aug. 1972.
 Bolman, W.M.: Community Control of the Community Mental Health Center: II. Case Examples, 181-186, Aug. 1972.
 Bowden, C.L.: see Maddux, J.F., jt. au.
 Bowden, C.L., and Maddux, J.F.: Methadone Maintenance: Myth and Reality, 435-439, Oct. 1972.
 Boylston, W.H., and Tuma, J.M.: Training of Mental Health Professionals Through the Use of the "Bug in the Ear," 92-95, July 1972.
 Braceland, F.J.: Austin M. Davies, 1900-1972 (In Mem.), 763-764, Dec. 1972.
 Braceland, F.J.: Changes in the Offing (Ed. N.), 736-737, Dec. 1972.
 Breggin, P.R.: Lobotomies: An Alert (Ltrs. to Ed.), 97-98, July 1972.
 Brodland, G.: see Clancy, J., jt. au.
 Brunt, H.H., Jr.: Report of the Speaker (Off. Act.), 512-513, Oct. 1972.
 Bunney, W.E., Jr.: see Goodwin, F.K., jt. au.
 Burnell, G.M., Dworsky, W.A., and Harrington, R.L.: Post-Abortion Group Therapy, 220-223, Aug. 1972.
 Busse, E.W.: The Presidential Address: There Are Decisions To Be Made, 1-9, July 1972.

C

- Castelnuovo-Tedesco, P.: see Ford, C.V., jt. au.
 Chafetz, M.E.: Alcoholism Criteria: An Important Step (Ed. N.), 214-215, Aug. 1972.

- Chapman, R.E.: see Bey, D.R., jt. au.
 Chappel, J.N.: see Levine, D.G., jt. au.
 Char, J.: Drug Abuse in Viet Nam, 463-465, Oct. 1972.
 Char, W.F.: reply to E.F. Kal, Abortions: Regaining Objectivity or Rationalization? (Ltrs. to Ed.), 485, Oct. 1972.
 Chayet, N.L.: The Overturning of Another Landmark (Ed. N.), 331-333, Sept. 1972.
 Cheng, L.Y.: discussion of J. Westermeyer, A Comparison of Amok and Other Homicide in Laos, 708-709, Dec. 1972.
 Chodoff, P.: The Effect of Third-Party Payment on the Practice of Psychotherapy, 540-545, Nov. 1972.
 Clancy, J., Brodland, G., and Fahr, S.: A Psychiatric Clerkship for Law Students, 322-326, Sept. 1972.
 Clanon, T.L.: see Jew, C.C., jt. au.
 Clark, D.: see Tancredi, L., jt. au.
 Clarkin, J.: see Shapiro, A.K., jt. au.
 Clayton, P.J.: see Guze, S.B., jt. au.
 Cloud, L.A.: see Seixas, F.A., jt. au.
 Coddington, R.D., and King, T.L.: Automated History Taking in Child Psychiatry, 276-282, Sept. 1972.
 Cohen, S.: Drug Use: Religion and Secularization (Ltrs. to Ed.), 97, July 1972.
 Cole, J.O.: see Stotsky, B.A., jt. au.
 Conrad, H.T.: see Weppner, R.S., jt. au.
 Crane, G.E.: Prevention and Management of Tardive Dyskinesia, 466-467, Oct. 1972.
 Cytryn, L., and McKnew, D.H., Jr.: Proposed Classification of Childhood Depression, 149-155, Aug. 1972.

D

- Dansak, D.A.: Secondary Gain in Long-Term Hemodialysis Patients, 352-355, Sept. 1972.
 Davidson, D.E.: see Ritter, R.M., jt. au.
 Davis, J.M.: see Janowsky, D.S., jt. au.
 Dean, S.R., and Thong, D.: Shamanism Versus Psychiatry in Bali, "Isle of the Gods": Some Modern Implications, 59-62, July 1972.
 Decker, J.B., and Stubblebine, J.M.: Crisis Intervention and Prevention of Psychiatric Disability: A Follow-Up Study, 725-729, Dec. 1972.
 Deem, M.A.: see Greenberg, L.M., jt. au.
 Devereaux, M.W., and McCormick, R.A.: Psychogenic Water Intoxication: A Case Report, 628-630, Nov. 1972.
 DiMascio, A.: see Agulnik, P.L., jt. au.
 Donahue, H.H.: Report of the Treasurer (Off. Act.), 508-511, Oct. 1972.
 Dorsey, J.M.: Thomas J. Heldt, 1883-1972 (In Mem.), 762, Dec. 1972.
 Dunner, D.L.: see Goodwin, F.K., jt. au.
 Dworsky, W.A.: see Burnell, G.M., jt. au.

E

- Eisler, R.M.: see Hersen, M., jt. au.
 Ellerbroek, W.C.: A New Window (Ltrs. to Ed.), 240, Aug. 1972.
 Ellerbroek, W.C.: The Reprint Collector's Pledge (Ltrs. to Ed.), 100, July 1972.
 Ellison, D.L.: see Wolford, J.A., jt. au.
 El-Yousef, M.K.: see Janowsky, D.S., jt. au.
 Eveloff, H.H., and McCreary, C.P.: The Attitudes of Patients and Their Trainee Therapists Toward Participation in Psychiatric Board Examinations, 616-620, Nov. 1972.
 Ewing, J.A.: see Rouse, B.A., jt. au.

F

- Fahr, S.: see Clancy, J., jt. au.
 Finnerty, R.J.: see Goldberg, H.L., jt. au.
 Fish, J.E., and Larr, C.J.: A Decade of Change in Drawings by Black Children, 421-425, Oct. 1972.
 Ford, C.V.: see Spaulding, R.C., jt. au.
 Ford, C.V., Castelnovo-Tedesco, P., and Long, K.D.: Women Who Seek Therapeutic Abortion: A Comparison with Women Who Complete Their Pregnancies, 546-552, Nov. 1972.
 Frazier, C.A.: Request for Information (Ltrs. to Ed.), 361, Sept. 1972.
 Frazier, S.H.: A Commentary on "The Pseudo-Regulation of American Psychiatry," 664-668, Dec. 1972.
 Freed, H.M.: Subcontracts for Community Development and Service, 568-573, Nov. 1972.
 Fried, S.R.: discussion of P. Ruiz and G. Saiger, Partial Hospitalization Within an Urban Slum, 92, July 1972.
 Friedman, C.M.: Unwed Motherhood: A Continuing Problem, 85-89, July 1972.
 Fuller, M.: see Kardener, S.H., jt. au.

G

- Galdston, R., and Hughes, M.C.: Pediatric Hospitalization as Crisis Intervention, 721-725, Dec. 1972.
 Gallemore, J.L., Jr., and Panton, J.H.: Inmate Responses to Lengthy Death Row Confinement, 167-171, Aug. 1972.
 Gallemore, J.L., Jr., and Wilson, W.P.: Adolescent Maladjustment or Affective Disorder? 608-612, Nov. 1972.
 Gelenberg, A.J.: Psychiatry as a Medical Specialty (Ltrs. to Ed.), 633-634, Nov. 1972.
 Gilbert, R.: see Van Stone, W.W., jt. au.
 Glass, G.S.: discussion of C. Salzman, J. Lieff, G.E. Kochansky, and R.I. Shader, The Psychology of Hallucinogenic Drug Discontinuers, 760-761, Dec. 1972.
 Goertzel, V.: see Lamb, H.R., jt. au.
 Goldberg, H.L., and Finnerty, R.J.: The Use of Doxepin in the Treatment of Symptoms of Anxiety Neurosis and Accompanying Depression: A Collaborative Controlled Study, 74-77, July 1972.
 Goldstein, R.L.: Those Who Kill Without Thinking (Ltrs. to Ed.), 766-767, Dec. 1972.
 Goodwin, F.K.: see Kotin, J., jt. au.
 Goodwin, F.K., Murphy, D.L., Dunner, D.L., and Bunney, W.E., Jr.: Lithium Response in Unipolar Versus Bipolar Depression, 44-47, July 1972.
 Gordon, M.W.: see Van der Velde, C.D., jt. au.
 Gould, R.L.: The Phases of Adult Life: A Study in Developmental Psychology, 521-531, Nov. 1972.
 Greden, J.F., and Morgan, D.W.: Amnesty's Impact Upon Drug Use: A Pre/Post Study, 392-397, Oct. 1972.
 Greenberg, L.M., Deem, M.A., and McMahon, S.: Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, 532-539, Nov. 1972.
 Greenblatt, M.: Administrative Psychiatry, 373-386, Oct. 1972.
 Guttmacher, J.A.: Cohesion and Hostility (Ltrs. to Ed.), 361-362, Sept. 1972.
 Guyden, T.E.: see Morgan, D.W., jt. au.
 Guze, S.B.: see Bibb, R.C., jt. au.
 Guze, S.B., Woodruff, R.A., Jr., and Clayton, P.J.: Sex, Age, and the Diagnosis of Hysteria (Briquet's Syndrome), 745-748, Dec. 1972.

H

- Hall, R.C.W., and Joffe, J.R.: Aberrant Response to Diazepam: A New Syndrome, 738-742, Dec. 1972.
- Halpern, W.L.: Some Psychiatric Sequelae to Crib Death, 398-402, Oct. 1972.
- Hankoff, L.D.: Ancient Descriptions of Organic Brain Syndrome: The "Kordiakos" of the *Talmud*, 233-236, Aug. 1972.
- Harinath, M.: see Hussain, M.Z., jt. au.
- Harrington, R.L.: see Burnell, G.M., jt. au.
- Hart, W.T., and Bassett, L.: Delivery of Services to Lower Socioeconomic Groups by a Suburban Community Mental Health Center, 191-196, Aug. 1972.
- Harth, P.: see Landau, R., jt. au.
- Hartmann, E.: see Watson, R., jt. au.
- Hays, P.: Determination of the Obsessional Personality, 217-219, Aug. 1972.
- Hedlund, J.L.: see Morgan, D.W., jt. au.
- Heiman, M.: New Abortion Laws and Help for Nurses (Ltrs. to Ed.), 360, Sept. 1972.
- Hempel, W.V.: Effects of Posture on Thinking (Ltrs. to Ed.), 768, Dec. 1972.
- Hersen, M., Eisler, R.M., Smith, B.S., and Agras, W.S.: A Token Reinforcement Ward for Young Psychiatric Patients, 228-233, Aug. 1972.
- Hitchcock, J.: see Wolford, J.A., jt. au.
- Hoaken, P.C.S.: Schizophrenia and Affective Psychosis: Additional Comments (Ltrs. to Ed.), 632-633, Nov. 1972.
- Holder, H.D., and Stratas, N.E.: A Systems Approach to Alcoholism Programming, 32-37, July 1972.
- Horowitz, M.J.: Psychiatric Training—the Center Must Hold (Ltrs. to Ed.), 636, Nov. 1972.
- Houck, J.H.: The Intractable Female Patient, 27-31, July 1972.
- Howells, J.G.: Monkey Therapists (Ltrs. to Ed.), 485-486, Oct. 1972.
- Hughes, M.C.: see Galdston, R., jt. au.
- Hussain, M.Z., and Harinath, M.: Helping Alcoholics Abstain: An Implantable Substance (Ltrs. to Ed.), 363, Sept. 1972.

J

- Janowsky, D.S., Davis, J.M., El-Yousef, M.K., and Serkerke, H.J.: Combined Anticholinergic Agents and Atropine-Like Delirium (Ltrs. to Ed.), 360-361, Sept. 1972.
- Jens, R.: see Ziskind, E., jt. au.
- Jew, C.C., Clanon, T.L., and Mattocks, A.L.: The Effectiveness of Group Psychotherapy in a Correctional Institution, 602-605, Nov. 1972.
- Joffe, J.R.: see Hall, R.C.W., jt. au.
- Jus, A.: see Jus, K., jt. au.
- Jus, K., Villezeuve, A., and Jus, A.: Tardive Dyskinesia and the Rabbit Syndrome During Wakefulness and Sleep (Ltrs. to Ed.), 765, Dec. 1972.

K

- Kaim, S.C.: see Seixas, F.A., jt. au.
- Kal, E.F.: Abortions: Regaining Objectivity or Rationalization? (Ltrs. to Ed.), 484-485, Oct. 1972.
- Kaplan, H.B.: see Pokorny, A.D., jt. au.
- Kardener, S.H., and Fuller, M.: The Firstborn Phenomenon Among Psychiatric Residents, 350-352, Sept. 1972.
- Kaufman, E.: discussion of J.L. Gallemler, Jr., and J.H.

- Panton, Inmate Responses to Lengthy Death Row Confinement, 171-172, Aug. 1972.
- Kennedy, R.B.: Character and Behavior Disorder: A Way to Discharge Men from the Service (Ltrs. to Ed.), 765-766, Dec. 1972.
- Kerstein, M.D.: Caring for the Terminally Ill: A Hospice (Ltrs. to Ed.), 237-238, Aug. 1972.
- Keskiner, A., Zalzman, M.J., Ruppert, E.H., and Ulett, G.A.: The Foster Community: A Partnership in Psychiatric Rehabilitation, 283-288, Sept. 1972.
- Keveles, G.: see Steadman, H.J., jt. au.
- Kimsey, L.R., Roberts, J.L., and Logan, D.L.: Death, Dying, and Denial in the Aged, 161-166, Aug. 1972.
- King, T.L.: see Coddington, R.D., jt. au.
- Klein, S.D.: see Simmons, R.G., jt. au.
- Kleinman, A.K.: Psychiatry in Mainland China: Additional Sources (Ltrs. to Ed.), 482-483, Oct. 1972.
- Kochansky, G.E.: see Salzman, C., jt. au.
- Koran, L.M.: reply to A.K. Kleinman and to L.J. Ravitz, Psychiatry in Mainland China: Additional Sources (Ltrs. to Ed.), 484, Oct. 1972.
- Kotin, J., and Goodwin, F.K.: Depression During Mania: Clinical Observations and Theoretical Implications, 679-686, Dec. 1972.
- Krainin, J.M.: Counter-Playing: A Group Therapy Technique, 600-601, Nov. 1972.
- Krainin, J.M.: Psychotherapy by Counter-Manipulation, 749-751, Dec. 1972.
- Kvarnes, R.G.: see Rittelmeyer, L.F., Jr., jt. au.

L

- Lamb, H.R., and Goertzel, V.: High Expectations of Long-Term Ex-State Hospital Patients, 471-475, Oct. 1972.
- Landau, R., Harth, P., Othnay, N., and Sharfhertz, C.: The Influence of Psychotic Parents on Their Children's Development, 38-43, July 1972.
- Langsley, D.G.: Crisis Intervention (Ed. N.), 734-736, Dec. 1972.
- Larr, C.J.: see Fish, J.E., jt. au.
- Lebensohn, Z.M.: reply to H.I. Posin and to W.G. Smith, The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), 359-360, Sept. 1972.
- Lebensohn, Z.M.: Walter Freeman, 1895-1972 (In Mem.), 356-357, Sept. 1972.
- Lester, D.: Aggression—Quantitative Data (Ltrs. to Ed.), 238, Aug. 1972.
- Levin, D.B.: see Levine, D.G., jt. au.
- Levine, D.G., Levin, D.B., Sloan, I.H., and Chappel, J.N.: Personality Correlates of Success in a Methadone Maintenance Program, 456-460, Oct. 1972.
- Levy, E.Z.: discussion of L. Cytryn and D.H. McKnew, Jr., Proposed Classification of Childhood Depression, 155, Aug. 1972.
- Lieber, A.L., and Sherin, C.R.: Homicides and the Lunar Cycle: Toward a Theory of Lunar Influence on Human Emotional Disturbance, 69-74, July 1972.
- Lief, H.I.: Sexual Behavior: Significant Changes (Ltrs. to Ed.), 768-769, Dec. 1972.
- Lieff, J.: see Salzman, C., jt. au.
- Lion, J.R.: The Role of Depression in the Treatment of Aggressive Personality Disorders, 347-349, Sept. 1972.
- Lipowski, Z.J.: Psychiatric Liaison with Neurology and Neurosurgery, 136-140, Aug. 1972.
- Lipp, M.R., and Benson, S.G.: Physician Use of Marijuana, Alcohol, and Tobacco, 612-616, Nov. 1972.

- Lipscomb, C.F.: An Attempt to Study Time Utilization in a Mental Health Program, 82-84, July 1972.
 Lipsius, L.H.: Reaching Black Professionals (Ltrs. to Ed.), 631, Nov. 1972.
 Little, J.M.: see Shaffer, J.W., jt. au.
 Logan, D.L.: see Kimsey, L.R., jt. au.
 Lomas, H.D.: Psychoanalysis: Out in the Cold? (Ltrs. to Ed.), 768, Dec. 1972.
 Long, K.D.: see Ford, C.V., jt. au.
 Lower, R.B.: Countertransference Resistances in the Supervisory Situation, 156-160, Aug. 1972.
 Lowry, T.P.: Vitamin E for Withdrawal Leg Cramps (Ltrs. to Ed.), 361, Sept. 1972.
 Lu, L.-M.: see Stotsky, B.A., jt. au.

M

- Maddux, J.F.: see Bowden, C.L., jt. au.
 Maddux, J.F., and Bowden, C.L.: Critique of Success with Methadone Maintenance, 440-446, Oct. 1972.
 Magier, I.: Metapsychiatry in the United States (Ltrs. to Ed.), 486, Oct. 1972.
 Marcotte, D.B.: Marijuana and Mutism, 475-477, Oct. 1972.
 Margetts, E.L.: On Reprints and Related Things (Ltrs. to Ed.), 239-240, Aug. 1972.
 Martin, M.: Community Mental Health Centers: Coming to Grips with Big Ideas (Ed. N.), 211-213, Aug. 1972.
 Mattocks, A.L.: see Jew, C.C., jt. au.
 McCormick, R.A.: see Devereaux, M.W., jt. au.
 McCrank, E.: The Staccato Syndrome: A New Definition (Ltrs. to Ed.), 238-239, Aug. 1972.
 McCreary, C.P.: see Eveloff, H.H., jt. au.
 McDermott, J.F., Jr.: discussion of J.E. Fish and C.J. Larr, A Decade of Change in Drawings by Black Children, 425-426, Oct. 1972.
 McKnew, D.H., Jr.: see Cytryn, L., jt. au.
 McMahon, S.: see Greenberg, L.M., jt. au.
 Melia, P., Sinanan, K., and O'Donaghue, F.: Goiter in Psychiatric Patients (Ltrs. to Ed.), 632, Nov. 1972.
 Miller, B.A.: see Pokorny, A.D., jt. au.
 Miller, M.H.: A Good Look—A Marvelous Book (Ltrs. to Ed.), 240, Aug. 1972.
 Miner, J.M.: see Schwartz, D.A., jt. au.
 Moore, P.: see Agulnik, P.L., jt. au.
 Mora, G.: 1972 Anniversaries, 652-657, Dec. 1972.
 Mora, G.: On the Bicentenary of the Birth of Esquirol (1772-1840), the First Complete Psychiatrist, 562-566, Nov. 1972.
 Mora, G.: The Relevance of History for the Community Mental Health Approach to Children, 408-414, Oct. 1972.
 Morgan, D.W.: see Greden, J.F., jt. au.
 Morgan, D.W., Weitzel, W.D., Guyden, T.E., Robinson, J.A., and Hedlund, J.L.: Comparing MMPI Statements and Mental Status Items, 693-697, Dec. 1972.
 Morgenstern, A.L.: A Systematic Approach for Oral Board Examinations in Psychiatry, 54-58, July 1972.
 Murphy, D.L.: Amine Precursors, Amines, and False Neurotransmitters in Depressed Patients, 141-148, Aug. 1972.
 Murphy, D.L.: see Goodwin, F.K., jt. au.

N

- Nathan, P.E.: see Allman, L.R., jt. au.
 National Council on Alcoholism, the Criteria Com-

mittee: Criteria for the Diagnosis of Alcoholism, 127-135, Aug. 1972.

- Neubauer, P.B.: see Ostow, M., jt. au.
 Nihira, K.: see Yusin, A., jt. au.
 Nussbaum, K.: see Shaffer, J.W., jt. au.

O

- O'Donaghue, F.: see Melia, P., jt. au.
 Ostow, M., Blumenthal, M.J., Arlow, J.A., and Neubauer, P.B.: The Jewishness of Jewish Young People: A Symposium, 553-561, Nov. 1972.
 Othnay, N.: see Landau, R., jt. au.

P

- Panton, J.H.: see Gallemore, J.L., Jr., jt. au.
 Perkins, M.E.: Methadone Maintenance: Expanding the Concept of Service (Ed. N.), 461-462, Oct. 1972.
 Perkins, M.E., and Richman, A.: Prevalence of Participation in Methadone Maintenance Programs, 447-450, Oct. 1972.
 Peters, J.J.: see Roether, H.A., jt. au.
 Pokorny, A.D., Miller, B.A., and Kaplan, H.B.: The Brief MAST: A Shortened Version of the Michigan Alcoholism Screening Test, 342-345, Sept. 1972.
 Posin, H.I.: The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), 358, Sept. 1972.
 Poze, R.S.: Heroin Addicts in a Community Mental Health Inpatient Unit, 206-210, Aug. 1972.

R

- Raskin, D.E.: Akathisia: A Side Effect To Be Remembered, 345-347, Sept. 1972.
 Raskin, D.E.: reply to J.A. Baxter, The Mini-Boards: Their Place in Psychiatric Training (Ltrs. to Ed.), 635-636, Nov. 1972.
 Ravitz, L.J.: Psychiatry in Mainland China: Additional Sources (Ltrs. to Ed.), 483-484, Oct. 1972.
 Revitch, E.: Neuropsychiatry—Additional Comments (Ltrs. to Ed.), 97, July 1972.
 Richman, A.: see Perkins, M.E., jt. au.
 Rittelmeyer, L.F., Jr., Kvarnes, R.G., and Schneider, I.: Continuing Education for Community Psychiatry, 578-582, Nov. 1972.
 Ritter, R.M., Davidson, D.E., and Robinson, T.A.: Comparison of Injectable Haloperidol and Chlorpromazine, 78-81, July 1972.
 Roberts, J.L.: see Kimsey, L.R., jt. au.
 Robinson, J.A.: see Morgan, D.W., jt. au.
 Robinson, T.A.: see Ritter, R.M., jt. au.
 Robitscher, J.: Courts, State Hospitals, and the Right to Treatment, 298-304, Sept. 1972.
 Robitscher, J.: The New Face of Legal Psychiatry, 315-321, Sept. 1972.
 Roether, H.A., and Peters, J.J.: reply to J.A. Guttmacher, Cohesion and Hostility (Ltrs. to Ed.), 362-363, Sept. 1972.
 Rosenberg, E.H.: Establishment of a Psychotherapy Training Department at Tel-Aviv University (Ltrs. to Ed.), 634-635, Nov. 1972.
 Rouse, B.A., and Ewing, J.A.: Marijuana and Other Drug Use by Graduate and Professional Students, 415-420, Oct. 1972.
 Rubinstein, D.: Rehospitalization Versus Family Crisis Intervention, 715-720, Dec. 1972.
 Ruiz, P., and Saiger, G.: Partial Hospitalization Within an Urban Slum, 89-91, July 1972.
 Rumbaut, R.D.: discussion of G. Mora, On the Bicenten-

ary of the Birth of Esquirol (1772-1840), the First Complete Psychiatrist, 566-567, Nov. 1972.
Ruppert, E.H.: see Keskiner, A., jt. au.

S

Saiger, G.: see Ruiz, P., jt. au.
Salzman, C., Lieff, J., Kochansky, G.E., and Shader, R.I.: The Psychology of Hallucinogenic Drug Discontinuers, 755-760, Dec. 1972.
Saul, S.D.: see Winkelman, N.W., Jr., jt. au.
Schildkraut, J.J.: see Watson, R., jt. au.
Schneider, I.: see Rittelmeyer, L.F., Jr., jt. au.
Schwartz, D.A., Weiss, A.T., and Miner, J.M.: Community Psychiatry and Emergency Service, 710-715, Dec. 1972.
Seixas, F.A., Eaim, S.C., and Cloud, L.A.: comment on M.E. Chafetz, Alcoholism Criteria: An Important Step (Ed. N.), 215-216, Aug. 1972.
Serkerke, H.J.: see Janowsky, D.S., jt. au.
Serposs, A.: see Westermeyer, J., jt. au.
Shader, R.I.: see Salzman, C., jt. au.
Shaffer, J.W., Nussbaum, K., and Little, J.M.: MMPI Profiles of Disability Insurance Claimants, 403-407, Oct. 1972.
Shapiro, A.K.: Gilles de la Tourette's Disease (Ltrs. to Ed.), 99, July 1972.
Shapiro, A.K., Shapiro, E., Wayne, H., and Clarkin, J.: The Psychopathology of Gilles de la Tourette's Syndrome, 427-434, Oct. 1972.
Shapiro, D.A.: Symbiosis in Adulthood, 289-293, Sept. 1972.
Shapiro, E.: see Shapiro, A.K., jt. au.
Sharfhertz, C.: see Landau, R., jt. au.
Sherin, C.R.: see Lieber, A.L., jt. au.
Siassi, I.: The Psychiatrist's Role in Family Planning, 48-53, July 1972.
Simmons, R.G., and Klein, S.D.: Family Non-communication: The Search for Kidney Donors, 687-692, Dec. 1972.
Sinanan, K.: see Melia, P., jt. au.
Sinay, R.: see Yusin, A., jt. au.
Sloan, I.H.: see Levine, D.G., jt. au.
Smith, B.S.: see Hersen, M., jt. au.
Smith, F.: see Wolford, J.A., jt. au.
Smith, W.G.: The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), 358-359, Sept. 1972.
Sniffin, C.M.: see Stotsky, B.A., jt. au.
Somerfeld, E.: see Ziskind, E., jt. au.
Sonis, A.C.: see Wolford, J.A., jt. au.
Spaulding, R.C., and Ford, C.V.: The *Pueblo* Incident: Psychological Reactions to the Stresses of Imprisonment and Repatriation, 17-26, July 1972.
Spotnitz, H.: Group Psychotherapy in Perspective (Ed. N.), 606-607, Nov. 1972.
Stanton, M.D. and Bardon, A.: Drug Flashbacks: Reported Frequency in a Military Population, 751-755, Dec. 1972.
Steadman, H.J., and Keveles, G.: The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1956-1970, 304-310, Sept. 1972.
Steiner, J.: discussion of W.W. Van Stone and R. Gilbert, Peer Confrontation Groups: What, Why, and Whether, 588-589, Nov. 1972.
Stephens, R.C.: see Weppner, R.S., jt. au.
Stevens, H.: reply to A.K. Shapiro, Gilles de la Tourette's Disease (Ltrs. to Ed.), 99, July 1972.

Stotsky, B.A.: Social and Clinical Issues in Geriatric Psychiatry, 117-126, Aug. 1972.
Stotsky, B.A., Cole, J.O., Lu, L-M., and Sniffin, C.M.: A Controlled Study of the Efficacy of Pentylene-tetrazol (Metrazol) with Hard-Core Hospitalized Psychogeriatric Patients, 387-391, Oct. 1972.
Stratas, N.E.: see Holder, H.D., jt. au.
Stubblebine, J.M.: see Decker, J.B., jt. au.
Suarez, J.M.: Psychiatry and the Criminal Law System, 293-297, Sept. 1972.
Suess, J.F.: Short-Term Psychotherapy with the Compulsive Personality and Obsessive-Compulsive Neurotic, 270-275, Sept. 1972.

T

Talkington, P.C.: Response to the Presidential Address, 10-11, July 1972.
Tamerin, J.S.: The Psychodynamics of Quitting Smoking in a Group, 589-594, Nov. 1972.
Tanay, E.: reply to G.M. Bates, Jr., Homicidal Acts of War, and to R.L. Goldstein, Those Who Kill Without Thinking (Ltrs. to Ed.), 767, Dec. 1972.
Tancredi, L., and Clark, D.: Psychiatry and the Legal Rights of Patients, 328-330, Sept. 1972.
Tarjan, G.: Highlights of the 125th Annual Meeting (Off. Act.), 113-116, July 1972.
Tarjan, G.: Report of the Secretary: Summary of Meetings of Board of Trustees and Executive Committee, May 1971-May 1972 (Off. Act.), 502-508, Oct. 1972.
Taylor, C.C.: Identical Twins: Concordance for Homosexuality? (Ltrs. to Ed.), 486-487, Oct. 1972.
Taylor, H.A.: see Allman, L.R., jt. au.
Taylor, R.L., and Torrey, E.F.: The Pseudo-Regulation of American Psychiatry, 658-662, Dec. 1972.
Tec, L.: Help for Adopting Parents (Ltrs. to Ed.), 99-100, July 1972.
Thong, D.: see Dean, S.R., jt. au.
Tompkins, H.J.: discussion of R.L. Taylor and E.F. Torrey, The Pseudo-Regulation of American Psychiatry, 662-663, Dec. 1972.
Tornquist, K.L.: see Bey, D.R., jt. au.
Torop, K.: see Torop, P., jt. au.
Torop, P., and Torop, K.: Hotlines and Youth Culture Values, 730-733, Dec. 1972.
Torrey, E.F.: see Taylor, R.L., jt. au.
Tuma, J.M.: see Boylston, W.H., jt. au.

U

Ulett, G.A.: see Keskiner, A., jt. au.

V

Vaillant, G.E.: Why Men Seek Psychotherapy: I. Results of a Survey of College Graduates, 645-651, Dec. 1972.
Van der Velde, C.D., and Gordon, M.W.: Biochemical and Pharmacological Variations in Manic-Depressive Illness, 337-342, Sept. 1972.
Van Stone, W.W., and Gilbert, R.: Peer Confrontation Groups: What, Why, and Whether, 583-588, Nov. 1972.
Veith, I.: Acupuncture: Ancient Enigma to East and West (Ed. N.), 333-336, Sept. 1972.
Villeneuve, A.: see Jus, K., jt. au.

W

Wachspress, M.: Goals and Functions of the Community Mental Health Center, 187-190, Aug. 1972.

- Wadsworth, M.L.: Peyote Use: A Case Report (Ltrs. to Ed.), 96, July 1972.
- Watson, R., Hartmann, E., and Schildkraut, J.J.: Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion, 263-269, Sept. 1972.
- Wayne, H.: see Shapiro, A.K., jt. au.
- Weiner, M.F.: discussion of J.S. Tamerin, The Psychodynamics of Quitting Smoking in a Group, 594-595, Nov. 1972.
- Weiss, A.T.: see Schwartz, D.A., jt. au.
- Weitzel, W.D.: see Morgan, D.W., jt. au.
- Weppner, R.S., Stephens, R.C., and Conrad, H.T.: Methadone: Some Aspects of Its Legal and Illegal Use, 451-455, Oct. 1972.
- Westermeyer, J.: A Comparison of Amok and Other Homicide in Laos, 703-708, Dec. 1972.
- Westermeyer, J., and Serposs, A.: A Third Case of Self-Enucleation (Ltrs. to Ed.), 484, Oct. 1972.
- Williams, R.L.: Comprehensive Health Planning (Ltrs. to Ed.), 237, Aug. 1972.
- Wilson, W.P.: see Gallemore, J.L., Jr., jt. au.
- Windle, C.: see Bass, R.D., jt. au.
- Winkelman, N.W., Jr., and Saul, S.D.: The Riddle of Suggestion, 477-481, Oct. 1972.
- Wittson, C.L., and Benschoter, R.: Two-Way Television: Helping the Medical Center Reach Out, 624-627, Nov. 1972.
- Wolford, J.A., Hitchcock, J., Ellison, D.L., Sonis, A.C., and Smith, F.: The Effect on State Hospitalization of a Community Mental Health/Mental Retardation Center, 202-206, Aug. 1972.
- Woodruff, R.A., Jr.: see Guze, S.B., jt. au.

Y

- Yusin, A., Sinay, R., and Nihira, K.: Adolescents in Crisis: Evaluation of a Questionnaire, 574-577, Nov. 1972.

Z

- Zalcman, M.J.: see Keskiner, A., jt. au.
- Ziferstein, I.: Group Psychotherapy in the Soviet Union, 595-600, Nov. 1972.
- Ziskind, E., Somerfeld, E., and Jens, R.: reply to P.C.S. Hoaken, Schizophrenia and Affective Psychosis: Additional Comments (Ltrs. to Ed.), 633, Nov. 1972.

Subject Index

ABORTION

- Abortions: Regaining Objectivity or Rationalization? (Ltrs. to Ed.), E.F. Kal, and reply of W.F. Char, 484-485, Oct. 1972.
- New Abortion Laws and Help for Nurses (Ltrs. to Ed.), M. Heiman, 360, Sept. 1972.
- Post-Abortion Group Therapy, G.M. Burnell, W.A. Dworsky, and R.L. Harrington, 220-223, Aug. 1972.
- The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), H.I. Posin, and reply of Z.M. Lebensohn, 358, 360, Sept. 1972.
- The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), W.G. Smith, and reply of Z.M. Lebensohn, 358-360, Sept. 1972.
- Women Who Seek Therapeutic Abortion: A Comparison with Women Who Complete Their Pregnancies, C.V. Ford, P. Castelnuevo-Tedesco, and K.D. Long, 546-552, Nov. 1972.

ACUPUNCTURE

- Acupuncture: Ancient Enigma to East and West (Ed. N.), I. Veith, 333-336, Sept. 1972.

ADMINISTRATIVE PSYCHIATRY

- Administrative Psychiatry, M. Greenblatt, 373-386, Oct. 1972.
- An Attempt to Study Time Utilization in a Mental Health Program, C.F. Lipscomb, 82-84, July 1972.
- Community Control of the Community Mental Health Center: I. Introduction, W.M. Bolman, 173-180, Aug. 1972.
- Community Control of the Community Mental Health Center: II. Case Examples, W.M. Bolman, 181-186, Aug. 1972.
- Courts, State Hospitals, and the Right to Treatment, J. Robitscher, 298-304, Sept. 1972.
- Subcontracts for Community Development and Service, H.M. Freed, 568-573, Nov. 1972.
- A Systems Approach to Alcoholism Programming, H.D. Holder and N.E. Stratas, 32-37, July 1972.

ADOLESCENTS

- Adolescent Maladjustment or Affective Disorder? J.L. Gallemore, Jr., and W.P. Wilson, 608-612, Nov. 1972.
- Adolescents in Crisis: Evaluation of a Questionnaire, A. Yusin, R. Sinay, and K. Nihira, 574-577, Nov. 1972.
- Hotlines and Youth Culture Values, P. Torop and K. Torop, 730-733, Dec. 1972.

ADOPTION

- Help for Adopting Parents (Ltrs. to Ed.), L. Tec, 99-100,

July 1972.

AFFECTIVE DISORDER

- Acute Brain Syndrome Associated with Lithium Therapy, P.L. Agulnik, A. DiMascio, and P. Moore, 621-623, Nov. 1972.
- Adolescent Maladjustment or Affective Disorder? J.L. Gallemore, Jr., and W.P. Wilson, 608-612, Nov. 1972.
- Amine Precursors, Amines, and False Neurotransmitters in Depressed Patients, D.L. Murphy, 141-148, Aug. 1972.
- Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion, R. Watson, E. Hartmann, and J.J. Schildkraut, 263-269, Sept. 1972.
- Biochemical and Pharmacological Variations in Manic-Depressive Illness, C.D. van der Velde and M.W. Gordon, 337-342, Sept. 1972.
- Depression During Mania: Clinical Observations and Theoretical Implications, J. Kotin and F.K. Goodwin, 679-686, Dec. 1972.
- Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.
- Goiter in Psychiatric Patients (Ltrs. to Ed.), P. Melia, K. Sinanan, and F. O'Donoghue, 632, Nov. 1972.
- Group Drinking During Stress: Effects on Drinking Behavior, Affect, and Psychopathology, L.R. Allman, H.A. Taylor, and P.E. Nathan, 669-678, Dec. 1972.
- Hysteria (Briquet's Syndrome) in a Psychiatric Hospital: The Significance of Secondary Depression, R.C. Bibb and S.B. Guze, 224-228, Aug. 1972.
- A Lithium Clinic, D.R. Bey, R.E. Chapman, and K.L. Tornquist, 468-470, Oct. 1972.
- Lithium Response in Unipolar Versus Bipolar Depression, F.K. Goodwin, D.L. Murphy, D.L. Dunner, and W.E. Bunney, Jr., 44-47, July 1972.
- Proposed Classification of Childhood Depression, L. Cytryn and D.H. McKnew, Jr., and discussion by E.Z. Levy, 149-155, Aug. 1972.
- The Role of Depression in the Treatment of Aggressive Personality Disorders, J.R. Lion, 347-349, Sept. 1972.
- Schizophrenia and Affective Psychosis: Additional Comments (Ltrs. to Ed.), P.C.S. Hoaken, and reply of E. Ziskind, E. Somerfeld, and R. Jens, 632-633, Nov. 1972.
- The Use of Doxepin in the Treatment of Symptoms of Anxiety Neurosis and Accompanying Depression: A Collaborative Controlled Study, H.L. Goldberg and R.J. Finnerty, 74-77, July 1972.

AGGRESSION AND VIOLENCE

- Aggression—Quantitative Data (Ltrs. to Ed.), D. Lester, 238, Aug. 1972.
- Cohesion and Hostility (Ltrs. to Ed.), J.A. Guttmacher, and reply of H.A. Roether and J.J. Peters, 361-363,

- Sept. 1972.
 The Community Adjustment and Criminal Activity of the Baxstrom Patients, 1966-1970, H.J. Steadman and G. Keveles, 304-310, Sept. 1972.
 A Comparison of Amok and Other Homicide in Laos, J. Westermeyer, and discussion by L.Y. Cheng, 703-709, Dec. 1972.
 Homicidal Acts of War (Ltrs. to Ed.), G.M. Bates, Jr., and reply of E. Tanay, 766-767, Dec. 1972.
 Homicides and the Lunar Cycle: Toward a Theory of Lunar Influence on Human Emotional Disturbance, A.L. Lieber and C.R. Sherin, 69-74, July 1972.
 The Presidential Address: There Are Decisions To Be Made, E.W. Busse, 1-9, July 1972.
 The Role of Depression in the Treatment of Aggressive Personality Disorders, J.R. Lion, 347-349, Sept. 1972.
 Those Who Kill Without Thinking (Ltrs. to Ed.), R.L. Goldstein, and reply of E. Tanay, 766-767, Dec. 1972.

AKATHISIA

- Akathisia: A Side Effect To Be Remembered, D.E. Raskin, 345-347, Sept. 1972.

ALCOHOLISM

- Alcoholism Criteria: An Important Step (Ed. N.), M.E. Chafetz, and comment by F.A. Seixas, S.C. Kaim, and L.A. Cloud, 214-216, Aug. 1972.
 The Brief MAST: A Shortened Version of the Michigan Alcoholism Screening Test, A.D. Pokorny, B.A. Miller, and H.B. Kaplan, 342-345, Sept. 1972.
 Criteria for the Diagnosis of Alcoholism, The Criteria Committee, National Council on Alcoholism, 127-135, Aug. 1972.
 Group Drinking During Stress: Effects on Drinking Behavior, Affect, and Psychopathology, L.R. Allman, H.A. Taylor, and P.E. Nathan, 669-678, Dec. 1972.
 Helping Alcoholics Abstain: An Implantable Substance (Ltrs. to Ed.), M.Z. Hussain and M. Harinath, 363, Sept. 1972.
 Homicidal Acts of War (Ltrs. to Ed.), G.M. Bates, Jr., and reply of E. Tanay, 766-767, Dec. 1972.
 Peer Confrontation Groups: What, Why, and Whether, W.W. Van Stone and R. Gilbert, and discussion by J. Steiner, 583-589, Nov. 1972.
 A Systems Approach to Alcoholism Programming, H.D. Holder and N.E. Stratas, 32-37, July 1972.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

- The American Board of Psychiatry and Neurology (Off. Act.), 255-256, Aug. 1972.
 The Attitudes of Patients and Their Trainee Therapists Toward Participation in Psychiatric Board Examinations, H.H. Eveloff and C.P. McCreary, 616-620, Nov. 1972.
 A Commentary on the "The Pseudo-Regulation of American Psychiatry," S.H. Frazier, 664-668, Dec. 1972.
 The Mini-Boards: Their Place in Psychiatric Training (Ltrs. to Ed.), J.A. Baxter, and reply of D.E. Raskin, 635-636, Nov. 1972.
 Neuropsychiatry—Additional Comments (Ltrs. to Ed.),

- E. Revitch, 97, July 1972.
 1972 Annual Report of the American Board of Psychiatry and Neurology (Off. Act.), 514-516, Oct. 1972.
 The Pseudo-Regulation of American Psychiatry, R.L. Taylor and E.F. Torrey, and discussion by H.J. Tompkins, 658-663, Dec. 1972.
 A Systematic Approach for Oral Board Examinations in Psychiatry, A.L. Morgenstern, 54-58, July 1972.

AMERICAN JOURNAL OF PSYCHIATRY

- Changes in the Offing (Ed. N.), F.J. Braceland, 736-737, Dec. 1972.
 A Good Look—A Marvelous Book (Ltrs. to Ed.), M.H. Miller, 240, Aug. 1972.
 On Reprints and Related Things (Ltrs. to Ed.), E.L. Margetts, 239-240, Aug. 1972.
 Psychoanalysis: Out in the Cold? (Ltrs. to Ed.), H.D. Lomas, 768, Dec. 1972.
 The Reprint Collector's Pledge (Ltrs. to Ed.), W.C. Ellersbroek, 100, July 1972.

AMERICAN PSYCHIATRIC ASSOCIATION

- Austin M. Davies, 1900-1972 (In Mem.), F.J. Braceland, 763-764, Dec. 1972.
 A Commentary on "The Pseudo-Regulation of American Psychiatry," S.H. Frazier, 664-668, Dec. 1972.
 Committee on Certification in Administrative Psychiatry (Off. Act.), 372, Sept. 1972.
 Comprehensive Health Planning (Ltrs. to Ed.), R.L. Williams, 237, Aug. 1972.
 Ewald William Busse, M.D., One Hundredth President, 1971-1972, W.E. Barton, 12-16, July 1972.
 Highlights of the 125th Annual Meeting (Off. Act.), G. Tarjan, 113-116, July 1972.
 On Reprints and Related Things (Ltrs. to Ed.), E.L. Margetts, 239-240, Aug. 1972.
 The Presidential Address: There Are Decisions To Be Made, E.W. Busse, 1-9, July 1972.
 Proposed Amendments to the Constitution and By-Laws (Off. Act.), 517-520, Oct. 1972.
 Report of the Medical Director (Off. Act.), W.E. Barton, 511-512, Oct. 1972.
 Report of the Secretary: Summary of Meetings of Board of Trustees and Executive Committee, May 1971-May 1972 (Off. Act.), G. Tarjan, 502-503, Oct. 1972.
 Report of the Speaker (Off. Act.), H.H. Brunt, Jr., 512-513, Oct. 1972.
 Report of the Treasurer (Off. Act.), H.H. Donahue, 508-511, Oct. 1972.
 Response to the Presidential Address, P.C. Talkington, 10-11, July 1972.

AMPHETAMINES

- Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion, R. Watson, E. Hartmann, and J.J. Schildkraut, 263-269, Sept. 1972.

ANIMAL STUDIES

- Monkey Therapists (Ltrs. to Ed.), J.G. Howells, 485-486,

Oct. 1972.

ANXIETY NEUROSIS

The Use of Doxepin in the Treatment of Symptoms of Anxiety Neurosis and Accompanying Depression: A Collaborative Controlled Study, H.L. Goldberg and R.J. Finnerty, 74-77, July 1972.

ATROPINE

Combined Anticholinergic Agents and Atropine-Like Delirium (Ltrs. to Ed.), D.S. Janowsky, J.M. Davis, M.K. El-Yousef, and H.J. Serkerke, 360-361, Sept. 1972.

BEHAVIORAL PSYCHIATRY

The Riddle of Suggestion, N.W. Winkelman, Jr., and S.D. Saul, 477-481, Oct. 1972.
A Token Reinforcement Ward for Young Psychiatric Patients, M. Hersen, R.M. Eisler, B.S. Smith, and W.S. Agras, 228-233, Aug. 1972.

BIOCHEMICAL STUDIES

Amine Precursors, Amines, and False Neurotransmitters in Depressed Patients, D.L. Murphy, 141-148, Aug. 1972.
Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion, R. Watson, E. Hartmann, and J.J. Schildkraut, 263-269, Sept. 1972.
Biochemical and Pharmacological Variations in Manic-Depressive Illness, C.D. van der Velde and M.W. Gordon, 337-342, Sept. 1972.
Depression During Mania: Clinical Observations and Theoretical Implications, J. Kotin and F.K. Goodwin, 679-686, Dec. 1972.
Homicides and the Lunar Cycle: Toward a Theory of Lunar Influence on Human Emotional Disturbance, A.L. Lieber and C.R. Sherin, 69-74, July 1972.
Lithium Response in Unipolar Versus Bipolar Depression, F.K. Goodwin, D.L. Murphy, D.L. Dunner, and W.E. Burney, Jr., 44-47, July 1972.

BIRTH CONTROL

The Psychiatrist's Role in Family Planning, I. Siassi, 48-53, July 1972.
The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), H.I. Posin, and reply of Z.M. Lebensohn, 358, 360, Sept. 1972.
The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), W.G. Smith, and reply of Z.M. Lebensohn, 358-360, Sept. 1972.
Unwed Motherhood: A Continuing Problem, C.M. Friedmar, 85-89, July 1972.
Women Who Seek Therapeutic Abortion: A Comparison with Women Who Complete Their Pregnancies, C.V. Ford, P. Castelnuovo-Tedesco, and K.D. Long, 546-552, Nov. 1972.

BIRTH ORDER

The Firstborn Phenomenon Among Psychiatric Residents, S.H. Kardener and M. Fuller, 350-352, Sept. 1972.

BOOK REVIEWS

Ackerknecht, E.H.: *Medicine and Ethnology: Selected Essays*. Edited by H.H. Walser and H.M. Koelbing, 497-498, Oct. 1972.
Ames, L.B., Métraux, R.W., and Walker, R.N.: *Adolescent Rorschach Responses: Development Trends from Ten to Sixteen Years*, rev. ed., 246-247, Aug. 1972.
Barbizet, J.: *Human Memory and Its Pathology*. Translated by D.K. Jardine, 105-106, July 1972.
Bardwick, J.M.: *Psychology of Women: A Study of Bio-Cultural Conflicts*, 489-490, Oct. 1972.
Baynes, H.G., tr., and Hull, R.F.C., reviser: *The Collected Works of C.G. Jung*, vol. 6: *Psychological Types*, 244, Aug. 1972.
Blaine, G.B., Jr., and McArthur, C.C.: *Emotional Problems of the Student*, 2nd ed., 491-492, Oct. 1972.
Braceland, F.J.: *The Institute of Living: The Hartford Retreat, 1822-1972*, 639-640, Nov. 1972.
California Committee on Therapeutic Abortion, and Reiterman, C., ed.: *Abortion and the Unwanted Child*, 772-773, Dec. 1972.
Cancro, R., ed.: *Intelligence: Genetic and Environmental Influences*, 488-489, Oct. 1972.
Cancro, R., ed.: *The Schizophrenic Syndrome: An Annual Review, 1971*, 241-242, Aug. 1972.
Carney, R.E., ed.: *Risk-Taking Behavior*, 105, July 1972.
Casriel, D., and Amen, G.: *Daytop: Three Addicts and Their Cure*, 494, Oct. 1972.
Cowdry, E.V., and Steinberg, F.U., eds.: *The Care of the Geriatric Patient*, rev. ed., 367-368, Sept. 1972.
Deloughery, G.W., Gebbie, K.M., and Neuman, B.M.: *Consultation and Community Organization in Community Mental Health Nursing*, 640, Nov. 1972.
Doob, L.W.: *Patterning of Time*, 495, Oct. 1972.
Elling, R.H., ed.: *National Health Care: Issues and Problems in Socialized Medicine*, 101-102, July 1972.
Finch, S.M., and Poznanski, E.O.: *Adolescent Suicide*, 108-109, July 1972.
Fodor, N.: *Freud, Jung, and Occultism*, 773-774, Dec. 1972.
Gardner, R.A.: *Therapeutic Communication with Children: The Mutual Storytelling Technique*, 496-497, Oct. 1972.
Genovés, S.: *Is Peace Inevitable? Aggression, Evolution, and Human Destiny*, 248-249, Aug. 1972.
Goodstein, L.D., and Lanyon, R.I., eds.: *Readings in Personality Assessment*, 106-107, July 1972.
Gorney, R.: *The Human Agenda*, 488, Oct. 1972.
Granville-Grossman, K.: *Recent Advances in Clinical Psychiatry*, 497, Oct. 1972.
Greenblatt, M., Sharaf, M.R., and Stone, E.M.: *Dynamics of Institutional Change: The Hospital in Transition*, 638-639, Nov. 1972.
Hacker, F.: *Aggression: Die Brutalisierung der modernen Welt*, 107-108, July 1972.
Halleck, S.L.: *The Politics of Therapy*, 492-493, Oct. 1972.
Henle, M., ed.: *The Selected Papers of Wolfgang Köhler*, 496, Oct. 1972.

- Himwich, H.E., ed.: *Biochemistry, Schizophrenias, and Affective Illnesses*, 771, Dec. 1972.
- Holt, R.R., ed.: *New Horizon for Psychotherapy: Autonomy as a Profession*, 770-771, Dec. 1972.
- Howells, J.G., ed.: *Modern Perspectives in Adolescent Psychiatry*, 640-641, Nov. 1972.
- Hubbard, D.G.: *The Skyjacker*, 774-775, Dec. 1972.
- Hunt, W.A., ed.: *Learning Mechanisms in Smoking*, 247-248, Aug. 1972.
- Josselyn, I.M.: *Adolescence*, 364, Sept. 1972.
- Kanner, L.: *Child Psychiatry*, 4th ed., 241, Aug. 1972.
- Keniston, K.: *Youth and Dissent: The Rise of a New Opposition*, 771-772, Dec. 1972.
- Kittrie, N.N.: *The Right To Be Different: Deviance and Enforced Therapy*, 365-366, Sept. 1972.
- Krystal, H., and Niederland, W.G., eds.: *Psychic Traumatization: Aftereffects in Individuals and Communities*, 249-250, Aug. 1972.
- Lanyon, R.I., and Goodstein, L.D.: *Personality Assessment*, 106-107, July 1972.
- Lazarus, A.A.: *Behavior Therapy & Beyond*, 490-491, Oct. 1972.
- Leites, N.: *The New Ego: Pitfalls in Current Thinking About Patients in Psychoanalysis*, 494-495, Oct. 1972.
- MacKinnon, R.A., and Michels, R.: *The Psychiatric Interview in Clinical Practice*, 368, Sept. 1972.
- Madow, L., and Snow, L.H., eds.: *The Psychodynamic Implications of the Physiological Studies on Psychomimetic Drugs*, 776, Dec. 1972.
- McGuire, M.T.: *Reconstructions in Psychoanalysis*, 243-244, Aug. 1972.
- Medvedev, Z.A., and Medvedev, R.: *A Question of Madness*. Translated by E. De Kadt, 242-243, Aug. 1972.
- Moss, C.S.: *Dreams, Images, and Fantasy: A Semantic Differential Casebook*, 104-105, July 1972.
- Nagera, H., ed.: *The Hampstead Clinic Psychoanalytic Library*, vol. 3: *Basic Psychoanalytic Concepts on the Theory of Instincts*, 364-365, Sept. 1972.
- Nagera, H., ed.: *The Hampstead Clinic Psychoanalytic Library*, vol. 4: *Basic Psychoanalytic Concepts on Metapsychology, Conflicts, Anxiety and Other Subjects*, 364-365, Sept. 1972.
- Noland, R.L., ed.: *Counseling Parents of the Ill and the Handicapped*, 774, Dec. 1972.
- Panzetta, A.F.: *Community Mental Health: Myth and Reality*, 102, July 1972.
- Pilowsky, I., and Maddison, D., eds.: *Psychiatry and the Community*, 248, Aug. 1972.
- Rains, P.M.: *Becoming an Unwed Mother: A Sociological Account*, 775-776, Dec. 1972.
- Reed, L. S., Myers, E.S., and Scheidemandel, P.L.: *Health Insurance and Psychiatric Care: Utilization and Cost*, 637, Nov. 1972.
- Rie, H.E., ed.: *Perspectives in Child Psychopathology*, 250-251, Aug. 1972.
- Schur, M.: *Freud: Living and Dying*, 637-638, Nov. 1972.
- Shaffer, T.L.: *Death, Property, and Lawyers: A Behavioral Approach*, 366-367, Sept. 1972.
- Shagass, C., ed.: *Modern Problems of Pharmacopsychiatry*, vol. 6: *The Role of Drugs in Community Psychiatry*, 498, Oct. 1972.
- Shands, H.C.: *The War with Words: Structure and Transcendence*, 108, July 1972.
- Snyder, S.H.: *Uses of Marijuana*, 497, Oct. 1972.
- Stebbins, R.A.: *Commitment to Deviance: The Non-professional Criminal in the Community*, 245-246, Aug. 1972.
- Stuart, M., ed., with Liu, W.T.: *The Emerging Woman: The Impact of Family Planning*, 495-496, Oct. 1972.
- Tiger, L., and Fox, R.: *The Imperial Animal*, 102-103, July 1972.
- Townsend, C.: *Old Age: The Last Segregation*. Ralph Nader's Study Group Report on Nursing Homes, 366, Sept. 1972.
- Vernon, M.D.: *Reading and Its Difficulties*, 641, Nov. 1972.
- Waldman, R.D.: *Humanistic Psychiatry: From Oppression to Choice*, 776, Dec. 1972.
- Weil-Malherbe, H., and Szara, S.I.: *The Biochemistry of Functional and Experimental Psychoses*, 244-245, Aug. 1972.
- Welch, B.L., and Welch, A.S., eds.: *Physiological Effects of Noise*, 493-494, Oct. 1972.
- Winnicott, D.W.: *Playing and Reality*, 103-104, July 1972.
- Winnicott, D.W.: *Therapeutic Consultations in Child Psychiatry*, 247, Aug. 1972, and correction, 487, Oct. 1972.
- Woody, R.H.: *Psychobehavioral Counseling and Therapy*, 249, Aug. 1972.

CHEMOTHERAPY

- Gilles de la Tourette's Disease (Ltrs. to Ed.), A.K. Shapiro, and reply of H. Stevens, 99, July 1972.
- Social and Clinical Issues in Geriatric Psychiatry, B.A. Stotsky, 117-126, Aug. 1972.

CHILDREN

- Automated History Taking in Child Psychiatry, R.D. Coddington and T.L. King, 276-282, Sept. 1972.
- Child Custody Laws: Their Psychiatric Implications, E.P. Benedek, 326-328, Sept. 1972.
- A Decade of Change in Drawings by Black Children, J.E. Fish and C.J. Larr, and discussion by J.F. McDermott, Jr., 421-426, Oct. 1972.
- Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.
- Experiences in Establishing School Consultation, H.S. Bloch, 63-68, July 1972.
- Help for Adopting Parents (Ltrs. to Ed.), L. Tec, 99-100, July 1972.
- The Influence of Psychotic Parents on Their Children's Development, R. Landau, P. Harth, N. Othnay, and C. Shafherz, 38-43, July 1972.
- Pediatric Hospitalization as Crisis Intervention, R. Galdston and M.C. Hughes, 721-725, Dec. 1972.
- Proposed Classification of Childhood Depression, L. Cytryn and D.H. McKnew, Jr., and discussion by E.Z. Levy, 149-155, Aug. 1972.
- The Relevance of History for the Community Mental Health Approach to Children, G. Mora, 408-414, Oct. 1972.
- Some Psychiatric Sequelae to Crib Death, W.I. Halpern, 398-402, Oct. 1972.
- Training of Mental Health Professionals Through the Use of the "Bug in the Ear," W.H. Boylston and J.M. Tuma, 92-95, July 1972.

CHLORPROMAZINE

- Comparison of Injectable Haloperidol and Chlorpromazine, R.M. Ritter, D.E. Davidson, and T.A. Robinson, 78-81, July 1972.
- Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.

CIGARETTE SMOKING

- Physician Use of Marijuana, Alcohol, and Tobacco, M.R. Lipp and S.G. Benson, 612-616, Nov. 1972.
- The Psychoynamics of Quitting Smoking in a Group, J.S. Tamerin, and discussion by M.F. Weiner, 589-595, Nov. 1972.

COLLEGE MENTAL HEALTH

- Marijuana and Other Drug Use by Graduate and Professional Students, B.A. Rouse and J.A. Ewing, 415-420, Oct. 1972.

COMMUNITY PSYCHIATRY

- An Attempt to Study Time Utilization in a Mental Health Program, C.F. Lipscomb, 82-84, July 1972.
- Community Control of the Community Mental Health Center: I. Introduction, W.M. Bolman, 173-180, Aug. 1972.
- Community Control of the Community Mental Health Center: II. Case Examples, W.M. Bolman, 181-186, Aug. 1972.
- Community Mental Health Centers: Coming to Grips with Big Ideas (Ed. N.), M. Martin, 211-213, Aug. 1972.
- Community Psychiatry and Emergency Service, D.A. Schwartz, A.T. Weiss, and J.M. Miner, 710-715, Dec. 1972.
- Continuing Education for Community Psychiatry, L.F. Rittelmeyer, Jr., R.G. Kvarnes, and I. Schneider, 578-582, Nov. 1972.
- Continuity of Care: An Approach to Measurement, R.D. Bass and C. Windle, 196-201, Aug. 1972.
- Crisis Intervention and Prevention of Psychiatric Disability: A Follow-Up Study, J.B. Decker and J.M. Stubblebine, 725-729, Dec. 1972.
- Delivery of Services to Lower Socioeconomic Groups by a Suburban Community Mental Health Center, W.T. Hart and L. Bassett, 191-196, Aug. 1972.
- The Effect on State Hospitalization of a Community Mental Health/Mental Retardation Center, J.A. Wolford, J. Hitchcock, D.L. Ellison, A.C. Sonis, and F. Smith, 202-206, Aug. 1972.
- Experiences in Establishing School Consultation, H.S. Bloch, 63-68, July 1972.
- The Foster Community: A Partnership in Psychiatric Rehabilitation, A. Keskiner, M.J. Zalcman, E.H. Rupert, and G.A. Ulett, 283-288, Sept. 1972.
- Goals and Functions of the Community Mental Health Center, M. Wachspress, 187-190, Aug. 1972.
- Heroin Addicts in a Community Mental Health Inpatient Unit, R.S. Poze, 206-210, Aug. 1972.

- High Expectations of Long-Term Ex-State Hospital Patients, H.R. Lamb and V. Goertzel, 471-475, Oct. 1972.
- Hotlines and Youth Culture Values, P. Torop and K. Torop, 730-733, Dec. 1972.
- Partial Hospitalization Within an Urban Slum, P. Ruiz and G. Saiger, and discussion by S.R. Fried, 89-92, July 1972.
- The Psychiatrist's Role in Family Planning, I. Siassi, 48-53, July 1972.
- Rehospitalization Versus Family Crisis Intervention, D. Rubinstein, 715-720, Dec. 1972.
- The Relevance of History for the Community Mental Health Approach to Children, G. Mora, 408-414, Oct. 1972.
- Subcontracts for Community Development and Service, H.M. Freed, 568-573, Nov. 1972.
- A Systems Approach to Alcoholism Programming, H.D. Holder and N.E. Stratas, 32-37, July 1972.

COMPUTERS

- Automated History Taking in Child Psychiatry, R.D. Coddington and T.L. King, 276-282, Sept. 1972.
- Homicides and the Lunar Cycle: Toward a Theory of Lunar Influence on Human Emotional Disturbance, A.L. Lieber and C.R. Sherin, 69-74, July 1972.
- A Systems Approach to Alcoholism Programming, H.D. Holder and N.E. Stratas, 32-37, July 1972.

CONSULTATION

- Change of Command in Combat: A Locus of Stress, D.R. Bey, Jr., and discussion by P.B. Bach, 698-702, Dec. 1972.
- Continuing Education for Community Psychiatry, L.F. Rittelmeyer, Jr., R.G. Kvarnes, and I. Schneider, 578-582, Nov. 1972.
- Experiences in Establishing School Consultation, H.S. Bloch, 63-68, July 1972.
- Goals and Functions of the Community Mental Health Center, M. Wachspress, 187-190, Aug. 1972.
- New Abortion Laws and Help for Nurses (Ltrs. to Ed.), M. Heiman, 360, Sept. 1972.
- Psychiatric Liaison with Neurology and Neurosurgery, Z.J. Lipowski, 136-140, Aug. 1972.
- Psychiatry and the Criminal Law System, J.M. Suarez, 293-297, Sept. 1972.
- Two-Way Television: Helping the Medical Center Reach Out, C.L. Wittson and R. Benschoter, 624-627, Nov. 1972.

CONTINUITY OF CARE

- Continuity of Care: An Approach to Measurement, R.D. Bass and C. Windle, 196-201, Aug. 1972.

COUNTERTRANSFERENCE

- Countertransference Resistances in the Supervisory Situation, R.B. Lower, 156-160, Aug. 1972.

CRISIS INTERVENTION

- Adolescents in Crisis: Evaluation of a Questionnaire, A. Yusin, R. Sinay, and K. Nihira, 574-577, Nov. 1972.
- Community Psychiatry and Emergency Service, D.A. Schwartz, A.T. Weiss, and J.M. Miner, 710-715, Dec. 1972.
- Crisis Intervention (Ed. N.), D.G. Langsley, 734-736, Dec. 1972.
- Crisis Intervention and Prevention of Psychiatric Disability: A Follow-Up Study, J.B. Decker and J.M. Stubblebine, 725-729, Dec. 1972.
- The Effectiveness of Group Psychotherapy in a Correctional Institution, C.C. Jew, T.L. Clanon, and A.L. Mattocks, 602-605, Nov. 1972.
- Hotlines and Youth Culture Values, P. Torop and K. Torop, 730-733, Dec. 1972.
- Pediatric Hospitalization as Crisis Intervention, R. Galdston and M.C. Hughes, 721-725, Dec. 1972.
- Rehospitalization Versus Family Crisis Intervention, D. Rubinstein, 715-720, Dec. 1972.

DEATH AND DYING

- Caring for the Terminally Ill: A Hospice (Ltrs. to Ed.), M.D. Kerstein, 237-238, Aug. 1972.
- Death, Dying, and Denial in the Aged, L.R. Kimsey, J.L. Roberts, and D.L. Logan, 161-166, Aug. 1972.
- Inmate Responses to Lengthy Death Row Confinement, J.L. Gallemore, Jr., and J.H. Pantton, and discussion by E. Kaufman, 167-172, Aug. 1972.
- Some Psychiatric Sequelae to Crib Death, W.I. Halpern, 398-402, Oct. 1972.

DEVELOPMENTAL PSYCHOLOGY

- The Influence of Psychotic Parents on Their Children's Development, R. Landau, P. Harth, N. Othnay, and C. Sharfhertz, 38-43, July 1972.
- The Lame Princess: A Study of the Remission of Psychiatric Symptoms Without Treatment, M. Beiser, 257-262, Sept. 1972.
- Monkey Therapists (Ltrs. to Ed.), J.G. Howells, 485-486, Oct. 1972.
- A New Window (Ltrs. to Ed.), W.C. Ellerbroek, 240, Aug. 1972.
- The Phases of Adult Life: A Study in Developmental Psychology, R.L. Gould, 521-531, Nov. 1972.

DEXTROAMPHETAMINE

- Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.

DIAGNOSIS

- Adolescent Maladjustment or Affective Disorder? J.L. Gallemore, Jr., and W.P. Wilson, 608-612, Nov. 1972.
- Akathisia: A Side Effect To Be Remembered, D.E. Raskin, 345-347, Sept. 1972.
- Alcoholism Criteria: An Important Step (Ed. N.), M.E.

Amer. J. Psychiat. 129:6, December 1972

- Chafetz, and comment by F.A. Seixas, S.C. Kaim, and L.A. Cloud, 214-216, Aug. 1972.
- Ancient Descriptions of Organic Brain Syndrome: The "Kordiakos" of the *Talmud*, L.D. Hankoff, 233-236, Aug. 1972.
- Automated History Taking in Child Psychiatry, R.D. Coddington and T.L. King, 276-282, Sept. 1972.
- The Brief MAST: A Shortened Version of the Michigan Alcoholism Screening Test, A.D. Pokorny, B.A. Miller, and H.B. Kaplan, 342-345, Sept. 1972.
- Criteria for the Diagnosis of Alcoholism, The Criteria Committee, National Council on Alcoholism, 127-135, Aug. 1972.
- Gilles de la Tourette's Disease (Ltrs. to Ed.), A.K. Shapiro, and reply of H. Stevens, 99, July 1972.
- MMP1 Profiles of Disability Insurance Claimants, J.W. Shaffer, K. Nussbaum, and J.M. Little, 403-407, Oct. 1972.
- Proposed Classification of Childhood Depression, L. Cytryn and D.H. McKnew, Jr., and discussion by E.Z. Levy, 149-155, Aug. 1972.
- The Psychopathology of Gilles de la Tourette's Syndrome, A.K. Shapiro, E. Shapiro, H. Wayne, and J. Clarkin, 427-434, Oct. 1972.
- The Staccato Syndrome: A New Definition (Ltrs. to Ed.), E. McCrank, 238-239, Aug. 1972.
- Symbiosis in Adulthood, D.A. Shapiro, 289-292, Sept. 1972.

DIAZEPAM

- Aberrant Response to Diazepam: A New Syndrome, R.C.W. Hall and J.R. Joffe, 738-742, Dec. 1972.

DISULFIRAM

- Helping Alcoholics Abstain: An Implantable Substance (Ltrs. to Ed.), M.Z. Hussain and M. Harirath, 363, Sept. 1972.

DIVORCE

- Child Custody Laws: Their Psychiatric Implications, E.P. Benedek, 326-328, Sept. 1972.
- The 1971 Amendment of the Illinois Statute on Confidentiality: A New Development in Privilege Law, J.S. Beigler, 311-315, Sept. 1972.

DOXEPIN

- The Use of Doxepin in the Treatment of Symptoms of Anxiety Neurosis and Accompanying Depression: A Collaborative Controlled Study, H.L. Goldberg and R.J. Finnerty, 74-77, July 1972.

DRUG DEPENDENCE

- Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion, R. Watson, E. Hartmann, and J.J. Schildkraut, 263-269, Sept. 1972.
- Critique of Success with Methadone Maintenance, J.F. Maddux and C.L. Bowden, 440-446, Oct. 1972.

- Drug Abuse in Viet Nam, J. Char, 463-465, Oct. 1972.
 Heroin Addicts in a Community Mental Health Inpatient Unit, R.S. Poze, 206-210, Aug. 1972.
 Methadone Maintenance: Expanding the Concept of Service (Ed. N.), M.E. Perkins, 461-462, Oct. 1972.
 Methadone Maintenance: Myth and Reality, C.L. Bowden and J.F. Maddux, and discussion by P.H. Blachly, 435-440, Oct. 1972.
 Methadone: Some Aspects of Its Legal and Illegal Use, R.S. Weppner, R.C. Stephens, and H.T. Conrad, 451-455, Oct. 1972.
 The Psychology of Hallucinogenic Drug Discontinuers, C. Salzman, J. Lief, G.E. Kochansky, and R.I. Shader, and discussion by G.S. Glass, 755-761, Dec. 1972.
 Vitamin E for Withdrawal Leg Cramps (Ltrs. to Ed.), T.P. Lowry, 361, Sept. 1972.

DRUG FLASHBACKS

- Drug Flashbacks: Reported Frequency in a Military Population, M.D. Stanton and A. Bardoni, 751-755, Dec. 1972.

DRUG SIDE EFFECTS

- Aberrant Response to Diazepam: A New Syndrome, R.C.W. Hall and J.R. Joffe, 738-742, Dec. 1972.
 Acute Brain Syndrome Associated with Lithium Therapy, P.L. Agulnik, A. DiMascio, and P. Moore, 621-623, Nov. 1972.
 Akathisia: A Side Effect To Be Remembered, D.E. Raskin, 345-347, Sept. 1972.
 Combined Anticholinergic Agents and Atropine-Like Delirium (Ltrs. to Ed.), D.S. Janowsky, J.M. Davis, M.K. El-Yousef, and H.J. Serkerke, 360-361, Sept. 1972.
 Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.
 Prevention and Management of Tardive Dyskinesia, G.E. Crane, 466-467, Oct. 1972.
 Tardive Dyskinesia and the Rabbit Syndrome During Wakefulness and Sleep (Ltrs. to Ed.), K. Jus, A. Ville-neuve, and A. Jus, 765, Dec. 1972.

DRUG STUDY

- Biochemical and Pharmacological Variations in Manic-Depressive Illness, C.D. van der Velde and M.W. Gordon, 337-342, Sept. 1972.
 Comparison of Injectable Haloperidol and Chlorpromazine, R.M. Ritter, D.E. Davidson, and T.A. Robinson, 78-81, July 1972.
 A Controlled Study of the Efficacy of Pentylentetrazol (Metrazol) with Hard-Core Hospitalized Psychogeriatric Patients, B.A. Stotsky, J.O. Cole, L-M. Lu, and C.M. Sniffin, 387-391, Oct. 1972.
 Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.
 Lithium Response in Unipolar Versus Bipolar Depression, F.K. Goodwin, D.L. Murphy, D.L. Dunner, and

- W.E. Bunney, Jr., 44-47, July 1972.
 The Use of Doxepin in the Treatment of Symptoms of Anxiety Neurosis and Accompanying Depression: A Collaborative Controlled Study, H.L. Goldberg and R.J. Finnerty, 74-77, July 1972.

DRUG TREATMENT PROGRAMS

- Amnesty's Impact Upon Drug Use: A Pre/Post Study, J.F. Greden and D.W. Morgan, 392-397, Oct. 1972.
 Critique of Success with Methadone Maintenance, J.F. Maddux and C.L. Bowden, 440-446, Oct. 1972.
 Methadone Maintenance: Expanding the Concept of Service (Ed. N.), M.E. Perkins, 461-462, Oct. 1972.
 Methadone Maintenance: Myth and Reality, C.L. Bowden and J.F. Maddux, and discussion by P.H. Blachly, 435-440, Oct. 1972.
 Methadone: Some Aspects of Its Legal and Illegal Use, R.S. Weppner, R.C. Stephens, and H.T. Conrad, 451-455, Oct. 1972.
 Peer Confrontation Groups: What, Why, and Whether, W.W. Van Stone and R. Gilbert, and discussion by J. Steiner, 583-589, Nov. 1972.
 Personality Correlates of Success in a Methadone Maintenance Program, D.G. Levine, D.B. Levin, I.H. Sloan, and J. N. Chappel, 456-460, Oct. 1972.
 Prevalence of Participation in Methadone Programs, M.E. Perkins and A. Richman, 447-450, Oct. 1972.

DRUG USAGE

- Amnesty's Impact Upon Drug Use: A Pre/Post Study, J.F. Greden and D.W. Morgan, 392-397, Oct. 1972.
 Drug Use: Religion and Secularization (Ltrs. to Ed.), S. Cohen, 97, July 1972.
 Marijuana and Other Drug Use by Graduate and Professional Students, B.A. Rouse and J.A. Ewing, 415-420, Oct. 1972.
 Physician Use of Marijuana, Alcohol, and Tobacco, M.R. Lipp and S.G. Benson, 612-616, Nov. 1972.
 The Staccato Syndrome: A New Definition (Ltrs. to Ed.), E. McCrank, 238-239, Aug. 1972.

ECT

- Hysteria (Briquet's Syndrome) in a Psychiatric Hospital: The Significance of Secondary Depression, R.C. Bibb and S.B. Guze, 224-228, Aug. 1972.

EDUCATION, PSYCHIATRIC

- Administrative Psychiatry, M. Greenblatt, 373-386, Oct. 1972.
 The Attitudes of Patients and Their Trainee Therapists Toward Participation in Psychiatric Board Examinations, H.H. Eveloff and C.P. McCreary, 616-620, Nov. 1972.
 A Commentary on "The Pseudo-Regulation of American Psychiatry," S.H. Frazier, 664-668, Dec. 1972.
 Continuing Education for Community Psychiatry, L.F. Rittelmeyer, Jr., R.G. Kvarnes, and I. Schneider, 578-582, Nov. 1972.
 Countertransference Resistances in the Supervisory Situ-

- ation, R.B. Lower, 156-160, Aug. 1972.
- Death, Dying, and Denial in the Aged, L.R. Kimsey, J.L. Roberts, and D.L. Logan, 161-166, Aug. 1972.
- Establishment of a Psychotherapy Training Department at Tel-Aviv University (Ltrs. to Ed.), E.H. Rosenberg, 634-635, Nov. 1972.
- The Firstborn Phenomenon Among Psychiatric Residents, S.H. Kardener and M. Fuller, 350-352, Sept. 1972.
- The Mini-Boards: Their Place in Psychiatric Training (Ltrs. to Ed.), J.A. Baxter, and reply of D.E. Raskin, 635-636, Nov. 1972.
- Neuropsychiatry—Additional Comments (Ltrs. to Ed.), E. Revitch, 97, July 1972.
- The New Face of Legal Psychiatry, J. Robitscher, 315-321, Sept. 1972.
- The Presidential Address: There Are Decisions To Be Made, E.W. Busse, 1-9, July 1972.
- The Pseudo-Regulation of American Psychiatry, R.L. Taylor and E.F. Torrey, and discussion by H.J. Tompkins, 658-663, Dec. 1972.
- A Psychiatric Clerkship for Law Students, J. Clancy, G. Brodland, and S. Fahr, 322-326, Sept. 1972.
- Psychiatric Liaison with Neurology and Neurosurgery, Z.J. Lipowski, 136-140, Aug. 1972.
- Psychiatric Training—the Center Must Hold (Ltrs. to Ed.), M.J. Horowitz, 636, Nov. 1972.
- Psychiatry and the Legal Rights of Patients, L. Tancredi and D. Clark, 328-330, Sept. 1972.
- Psychiatry as a Medical Specialty (Ltrs. to Ed.), A.J. Gelenberg, 633-634, Nov. 1972.
- Psychoanalysis: Out in the Cold? (Ltrs. to Ed.), H.D. Lomas, 768, Dec. 1972.
- A Systematic Approach for Oral Board Examinations in Psychiatry, A.L. Morgenstern, 54-58, July 1972.
- Training of Mental Health Professionals Through the Use of the "Bug in the Ear," W.H. Boylston and J.M. Tuma, 92-95, July 1972.
- Two-Way Television: Helping the Medical Center Reach Out, C.L. Wittson and R. Benschoter, 624-627, Nov. 1972.
- EEG
- Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion, R. Watson, E. Hartmann, and J.J. Schildkraut, 263-269, Sept. 1972.
- ETHICS
- The Effect of Third-Party Payment on the Practice of Psychotherapy, P. Chodoff, 540-545, Nov. 1972.
- The Importance of Psychiatrists' Telling Patients the Truth, W.S. Appleton, 742-745, Dec. 1972.
- The 1971 Amendment of the Illinois Statute on Confidentiality: A New Development in Privilege Law, J.S. Beigler, 311-315, Sept. 1972.
- FAMILY PROCESSES
- Determination of the Obsessional Personality, P. Hays, 217-219, Aug. 1972.
- Family Noncommunication: The Search for Kidney Donors, R.G. Simmons and S.D. Klein, 687-692, Dec. 1972.
- The Firstborn Phenomenon Among Psychiatric Residents, S.H. Kardener and M. Fuller, 350-352, Sept. 1972.
- Help for Adopting Parents (Ltrs. to Ed.), L. Tec, 99-100, July 1972.
- The Influence of Psychotic Parents on Their Children's Development, R. Landau, P. Harth, N. Othnay, and C. Sharfheitz, 38-43, July 1972.
- The Intractable Female Patient, J.H. Houck, 27-31, July 1972.
- The Jewishness of Jewish Young People: A Symposium, M. Ostow, M.J. Blumenthal, J.A. Arlow, and P.B. Neubauer, 553-561, Nov. 1972.
- Pediatric Hospitalization as Crisis Intervention, R. Galdston and M.C. Hughes, 721-725, Dec. 1972.
- The Psychiatrist's Role in Family Planning, I. Siassi, 48-53, July 1972.
- Rehospitalization Versus Family Crisis Intervention, D. Rubinstein, 715-720, Dec. 1972.
- Social and Clinical Issues in Geriatric Psychiatry, B.A. Stotsky, 117-126, Aug. 1972.
- Some Psychiatric Sequelae to Crib Death, W.I. Halpern, 398-402, Oct. 1972.
- Symbiosis in Adulthood, D.A. Shapiro, 289-292, Sept. 1972.
- FOLLOW-UP STUDIES
- The Community Adjustment and Criminal Activity of the Baxstrom Patients, 1966-1970, H.J. Steadman and G. Keveles, 304-310, Sept. 1972.
- Crisis Intervention and Prevention of Psychiatric Disability: A Follow-Up Study, J.B. Decker and J.M. Stubblebine, 725-729, Dec. 1972.
- High Expectations of Long-Term Ex-State Hospital Patients, H.R. Lamb and V. Goertzel, 471-475, Oct. 1972.
- The Lame Princess: A Study of the Remission of Psychiatric Symptoms Without Treatment, M. Beiser, 257-262, Sept. 1972.
- Proposed Classification of Childhood Depression, L. Cytryn and D.H. McKnew, Jr., and discussion by E.Z. Levy, 149-155, Aug. 1972.
- FORENSIC PSYCHIATRY
- Child Custody Laws: Their Psychiatric Implications; E.P. Benedek, 326-328, Sept. 1972.
- The Community Adjustment and Criminal Activity of the Baxstrom Patients, 1966-1970, H.J. Steadman and G. Keveles, 304-310, Sept. 1972.
- Courts, State Hospitals, and the Right to Treatment, J. Robitscher, 298-304, Sept. 1972.
- The New Face of Legal Psychiatry, J. Robitscher, 315-321, Sept. 1972.
- The 1971 Amendment of the Illinois Statute on Confidentiality: A New Development in Privilege Law, J.S. Beigler, 311-315, Sept. 1972.
- The Overturning of Another Landmark (Ed. N.), N.L. Chayet, 331-333, Sept. 1972.
- A Psychiatric Clerkship for Law Students, J. Clancy, G. Brodland, and S. Fahr, 322-326, Sept. 1972.
- Psychiatry and the Criminal Law System, J.M. Suarez, 293-297, Sept. 1972.

Psychiatry and the Legal Rights of Patients, L. Tancredi and D. Clark, 328-330, Sept. 1972.

GENERAL PSYCHIATRY

- A Commentary on "The Pseudo-Regulation of American Psychiatry," S.H. Frazier, 664-668, Dec. 1972.
 Courts, State Hospitals, and the Right to Treatment, J. Robitscher, 298-304, Sept. 1972.
 Ewald William Busse, M.D., One Hundredth President, 1971-1972, W.E. Barton, 12-16, July 1972.
 The Firstborn Phenomenon Among Psychiatric Residents, S.H. Kardener and M. Fuller, 350-352, Sept. 1972.
 The Importance of Psychiatrists' Telling Patients the Truth, W.S. Appleton, 742-745, Dec. 1972.
 Neuropsychiatry—Additional Comments (Ltrs. to Ed.), E. Revitch, 97, July 1972.
 The New Face of Legal Psychiatry, J. Robitscher, 315-321, Sept. 1972.
 The Presidential Address: There Are Decisions To Be Made, E.W. Busse, 1-9, July 1972.
 The Pseudo-Regulation of American Psychiatry, R.L. Taylor and E.F. Torrey, and discussion by H.J. Tompkins, 658-663, Dec. 1972.
 A Psychiatric Clerkship for Law Students, J. Clancy, G. Brodland, and S. Fahr, 322-326, Sept. 1972.
 Psychiatric Liaison with Neurology and Neurosurgery, Z.J. Lipowski, 136-140, Aug. 1972.
 Psychiatric Training—the Center Must Hold (Ltrs. to Ed.), M.J. Horowitz, 636, Nov. 1972.
 Psychiatry and the Criminal Law System, J.M. Suarez, 293-297, Sept. 1972.
 Psychiatry as a Medical Specialty (Ltrs. to Ed.), A.J. Gelenberg, 633-634, Nov. 1972.
 The Reprint Collector's Pledge (Ltrs. to Ed.), W.C. Ellerbrock, 100, July 1972.
 Response to the Presidential Address, P.C. Talkington, 10-11, July 1972.
 Thomas J. Heldt, 1883-1972 (In Mem.), J.M. Dorsey, 762, Dec. 1972.
 Walter Freeman, 1895-1972 (In Mem.), Z.M. Lebensohn, 356-357, Sept. 1972.

GENETIC STUDIES

- Determination of the Obsessional Personality, P. Hays, 217-219, Aug. 1972.
 Identical Twins: Concordance for Homosexuality? (Ltrs. to Ed.), C.C. Taylor, 486-487, Oct. 1972.

GERIATRIC PSYCHIATRY

- A Controlled Study of the Efficacy of Pentylentetrazol (Metrazol) with Hard-Core Hospitalized Psychogeriatric Patients, B.A. Stotsky, J.O. Cole, L.-M. Lu, and C.M. Sniffin, 387-391, Oct. 1972.
 Death, Dying, and Denial in the Aged, L.R. Kimsey, J.L. Roberts, and D.L. Logan, 161-166, Aug. 1972.
 The Presidential Address: There Are Decisions To Be Made, E.W. Busse, 1-9, July 1972.
 Response to the Presidential Address, P.C. Talkington, 10-11, July 1972.
 Social and Clinical Issues in Geriatric Psychiatry, B.A.

Stotsky, 117-126, Aug. 1972.

GILLES DE LA TOURETTE'S SYNDROME

- Gilles de la Tourette's Disease (Ltrs. to Ed.), A.K. Shapiro, and reply of H. Stevens, 99, July 1972.
 The Psychopathology of Gilles de la Tourette's Syndrome, A.K. Shapiro, E. Shapiro, H. Wayne, and J. Clarkin, 427-434, Oct. 1972.

GROUP PROCESSES

- Change of Command in Combat: A Locus of Stress, D.R. Bey, Jr., and discussion by P.B. Bach, 698-702, Dec. 1972.
 Cohesion and Hostility (Ltrs. to Ed.), J.A. Guttmacher, and reply of H.A. Roether and J.J. Peters, 361-363, Sept. 1972.
 Counter-Playing: A Group Therapy Technique, J.M. Krainin, 600-601, Nov. 1972.
 The Effectiveness of Group Psychotherapy in a Correctional Institution, C.C. Jew, T.L. Clanon, and A.L. Mattocks, 602-605, Nov. 1972.
 Group Drinking During Stress: Effects on Drinking Behavior, Affect, and Psychopathology, L.R. Allman, H.A. Taylor, and P.E. Nathan, 669-678, Dec. 1972.
 Group Psychotherapy in Perspective (Ed. N.), H. Spontnitz, 606-607, Nov. 1972.
 Group Psychotherapy in the Soviet Union, I. Ziferstein, 595-600, Nov. 1972.
 Inmate Responses to Lengthy Death Row Confinement, J.L. Gallemore, Jr., and J.H. Panton, and discussion by E. Kaufman, 167-172, Aug. 1972.
 Peer Confrontation Groups: What, Why, and Whether, W.W. Van Stone and R. Gilbert, and discussion by J. Steiner, 583-589, Nov. 1972.
 Post-Abortion Group Therapy, G.M. Burnell, W.A. Dworsky, and R.L. Harrington, 220-223, Aug. 1972.
 The Psychodynamics of Quitting Smoking in a Group, J.S. Tamerin, and discussion by M.F. Weiner, 589-595, Nov. 1972.
 Social and Clinical Issues in Geriatric Psychiatry, B.A. Stotsky, 117-126, Aug. 1972.

HALLUCINOGENS

- Drug Flashbacks: Reported Frequency in a Military Population, M.D. Stanton and A. Bardoni, 751-755, Dec. 1972.
 Drug Use: Religion and Secularization (Ltrs. to Ed.), S. Cohen, 97, July 1972.
 Peyote Use: A Case Report (Ltrs. to Ed.), M.L. Wadsworth, and reply of R.L. Bergman, 96-97, July 1972.
 The Psychology of Hallucinogenic Drug Discontinuers, C. Saizman, J. Lieff, G.E. Kochansky, and R.I. Shader, and discussion by G.S. Glass, 755-761, Dec. 1972.
 A Third Case of Self-Enucleation (Ltrs. to Ed.), J. Westermeyer and A. Serposs, 484, Oct. 1972.

HALOPERIDOL

- Comparison of Injectable Haloperidol and Chlorpromazine, R.M. Ritter, D.E. Davidson, and T.A. Robinson,

78-81, July 1972.

HEALTH INSURANCE

- The Effect of Third-Party Payment on the Practice of Psychotherapy, P. Chodoff, 540-545, Nov. 1972.
- MMPI Profiles of Disability Insurance Claimants, J.W. Shaffer, K. Nussbaum, and J.M. Little, 403-407, Oct. 1972.

HEROIN

- Helping Alcoholics Abstain: An Implantable Substance (Ltrs. to Ed.), M.Z. Hussain and M. Harinath, 363, Sept. 1972.
- Heroin Addicts in a Community Mental Health Inpatient Unit, R.S. Poze, 206-210, Aug. 1972.
- Vitamin E for Withdrawal Leg Cramps (Ltrs. to Ed.), T.P. Lowry, 361, Sept. 1972.

HISTORY

- Acupuncture: Ancient Enigma to East and West (Ed. N.), I. Veith, 333-336, Sept. 1972.
- Ancient Descriptions of Organic Brain Syndrome: The "Kordiakos" of the *Talmud*, L.D. Hankoff, 233-236, Aug. 1972.
- A Commentary on "The Pseudo-Regulation of American Psychiatry," S.H. Frazier, 664-668, Dec. 1972.
- Group Psychotherapy in the Soviet Union, I. Ziferstein, 595-600, Nov. 1972.
- 1972 Anniversaries, G. Mora, 652-657, Dec. 1972.
- On the Bicentenary of the Birth of Esquirol (1772-1840), the First Complete Psychiatrist, G. Mora, and discussion by R.D. Rumbaut, 562-567, Nov. 1972.
- On Reprints and Related Things (Ltrs. to Ed.), E.L. Margetts, 239-240, Aug. 1972.
- The Relevance of History for the Community Mental Health Approach to Children, G. Mora, 408-414, Oct. 1972.
- The Riddle of Suggestion, N.W. Winkelman, Jr., and S.D. Saul, 477-481, Oct. 1972.

HOSPITALIZATION

- Caring for the Terminally Ill: A Hospice (Ltrs. to Ed.), M.D. Kerstein, 237-238, Aug. 1972.
- The Community Adjustment and Criminal Activity of the Baxstrom Patients, 1966-1970, H.J. Steadman and G. Keveles, 304-310, Sept. 1972.
- Community Control of the Community Mental Health Center: I. Introduction, W.M. Bolman, 173-180, Aug. 1972.
- Courts, State Hospitals, and the Right to Treatment, J. Robitscher, 298-304, Sept. 1972.
- The Effect on State Hospitalization of a Community Mental Health/Mental Retardation Center, J.A. Wolford, J. Hitchcock, D.L. Ellison, A.C. Sonis, and F. Smith, 202-206, Aug. 1972.
- The Foster Community: A Partnership in Psychiatric Rehabilitation, A. Keskiner, M.J. Zalcman, E.H. Rupert, and G.A. Ulett, 283-288, Sept. 1972.
- Heroin Addicts in a Community Mental Health In-

- patient Unit, R.S. Poze, 206-210, Aug. 1972.
- High Expectations of Long-Term Ex-State Hospital Patients, H.R. Lamb and V. Goertzel, 471-475, Oct. 1972.
- The Intractable Female Patient, J.H. Houck, 27-31, July 1972.
- Partial Hospitalization Within an Urban Slum, P. Ruiz and G. Saiger, and discussion by S.R. Fried, 89-92, July 1972.
- Pediatric Hospitalization as Crisis Intervention, R. Galdston and M.C. Hughes, 721-725, Dec. 1972.
- Psychiatry and the Legal Rights of Patients, L. Tancredi and D. Clark, 328-330, Sept. 1972.
- Rehospitalization Versus Family Crisis Intervention, D. Rubinstein, 715-720, Dec. 1972.
- Secondary Gain in Long-Term Hemodialysis Patients, D.A. Dansak, 352-355, Sept. 1972.

HYDROXYZINE

- Effects of Dextroamphetamine, chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.

HYPERKINESIS

- Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.

HYSTERIA

- Hysteria (Briquet's Syndrome) in a Psychiatric Hospital: The Significance of Secondary Depression, R.C. Bibb and S.B. Guze, 224-228, Aug. 1972.
- Sex, Age, and the Diagnosis of Hysteria (Briquet's Syndrome), S.B. Guze, R.A. Woodruff, Jr., and P.J. Clayton, 745-748, Dec. 1972.

IMIPRAMINE

- Biochemical and Pharmacological Variations in Manic-Depressive Illness, C.D. van der Velde and M.W. Gordon, 337-342, Sept. 1972.

IMPRISONMENT

- The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-1970, H.J. Steadman and G. Keveles, 304-310, Sept. 1972.
- The Effectiveness of Group Psychotherapy in a Correctional Institution, C.C. Jew, T.L. Clanon, and A.L. Matlocks, 602-605, Nov. 1972.
- Inmate Responses to Lengthy Death Row Confinement, J.L. Gallemore, Jr., and J.H. Pantton, and discussion by E. Kaufman, 167-172, Aug. 1972.
- Psychotherapy by Counter-Manipulation, J.M. Kainin, 749-751, Dec. 1972.
- The *Pueblo* Incident: Psychological Reactions to the Stresses of Imprisonment and Repatriation, R.C.

Spaulding and C.V. Ford, 17-26, July 1972.

KINESICS

Effects of Posture on Thinking (Ltrs. to Ed.), W.V. Hempel, 768, Dec. 1972.

LITHIUM

Acute Brain Syndrome Associated with Lithium Therapy, P.L. Agulnik, A. DiMascio, and P. Moore, 621-623, Nov. 1972.

Biochemical and Pharmacological Variations in Manic-Depressive Illness, C.D. van der Velde and M.W. Gordon, 337-342, Sept. 1972.

A Lithium Clinic, D.R. Bey, R.E. Chapman, and K.L. Tornquist, 468-470, Oct. 1972.

Lithium Response in Unipolar Versus Bipolar Depression, F.K. Goodwin, D.L. Murphy, D.L. Dunner, and W.E. Bunney, Jr., 44-47, July 1972.

LOBOTOMY

Lobotomies: An Alert (Ltrs. to Ed.), P.R. Breggin, 97-98, July 1972.

MARIJUANA

Drug Flashbacks: Reported Frequency in a Military Population, M.D. Stanton and A. Bardoni, 751-755, Dec. 1972.

Helping Alcoholics Abstain: An Implantable Substance (Ltrs. to Ed.), M.Z. Hussain and M. Harinath, 363, Sept. 1972.

Marijuana and Mutism, D.B. Marcotte, 475-477, Oct. 1972.

Marijuana and Other Drug Use by Graduate and Professional Students, B.A. Rouse and J.A. Ewing, 415-420, Oct. 1972.

Physician Use of Marijuana, Alcohol, and Tobacco, M.R. Lipp and S.G. Benson, 612-616, Nov. 1972.

MESCALINE

Peyote Use: A Case Report (Ltrs. to Ed.), M.L. Wadsworth, and reply of R.L. Bergman, 96-97, July 1972.

METAPSYCHIATRY

Metapsychiatry in the United States (Ltrs. to Ed.), I. Magier, 486, Oct. 1972.

METHADONE

Critique of Success with Methadone Maintenance, J.F. Maddux and C.L. Bowden, 440-446, Oct. 1972.

Helping Alcoholics Abstain: An Implantable Substance (Ltrs. to Ed.), M.Z. Hussain and M. Harinath, 363, Sept. 1972.

Methadone Maintenance: Expanding the Concept of Ser-

vice (Ed. N.), M.E. Perkins, 461-462, Oct. 1972.

Methadone Maintenance: Myth and Reality, C.L. Bowden and J.F. Maddux, and discussion by P.H. Blachly, 435-440, Oct. 1972.

Methadone: Some Aspects of Its Legal and Illegal Use, R.S. Weppner, R.C. Stephens, and H.T. Conrad, 451-455, Oct. 1972.

Personality Correlates of Success in a Methadone Maintenance Program, D.G. Levine, D.B. Levin, I.H. Sloan, and J.N. Chappel, 456-460, Oct. 1972.

Prevalence of Participation in Methadone Programs, M.E. Perkins and A. Richman, 447-450, Oct. 1972.

MILITARY PSYCHIATRY

Amnesty's Impact Upon Drug Use: A Pre/Post Study, J.F. Greden and D.W. Morgan, 392-397, Oct. 1972.

Change of Command in Combat: A Locus of Stress, D.R. Bey, Jr., and discussion by P.B. Bach, 698-702, Dec. 1972.

Character and Behavior Disorder: A Way to Discharge Men from the Service (Ltrs. to Ed.), R.B. Kennedy, 765-766, Dec. 1972.

Drug Abuse in Viet Nam, J. Char, 463-465, Oct. 1972.

Drug Flashbacks: Reported Frequency in a Military Population, M.D. Stanton and A. Bardoni, 751-755, Dec. 1972.

Psychotherapy by Counter-Manipulation, J.M. Krainin, 749-751, Dec. 1972.

The *Pueblo* Incident: Psychological Reactions to the Stresses of Imprisonment and Repatriation, R.C. Spaulding and C.V. Ford, 17-26, July 1972.

A Token Reinforcement Ward for Young Psychiatric Patients, M. Hersen, R.M. Eisler, B.S. Smith, and W.S. Agras, 228-233, Aug. 1972.

NEUROLOGY

Neuropsychiatry—Additional Comments (Ltrs. to Ed.), E. Revitch, 97, July 1972.

Psychiatric Liaison with Neurology and Neurosurgery, Z.J. Lipowski, 136-140, Aug. 1972.

NURSING

Abortions: Regaining Objectivity or Rationalization? (Ltrs. to Ed.), E.F. Kal, and reply of W.F. Char, 484-485, Oct. 1972.

New Abortion Laws and Help for Nurses (Ltrs. to Ed.), M. Heiman, 360, Sept. 1972.

OBITUARIES

Austin M. Davies, 1900-1972 (In Mem.), F.J. Braceland, 763-764, Dec. 1972.

Thomas J. Heldt, 1883-1972 (In Mem.), J.M. Dorsey, 762, Dec. 1972.

Walter Freeman, 1895-1972 (In Mem.), Z.M. Lebensohn, 356-357, Sept. 1972.

OBSESSIONAL NEUROSIS

Determination of the Obsessional Personality, P. Hays,

- 217-219, Aug. 1972.
Short-Term Psychotherapy with the Compulsive Personality and the Obsessive-Compulsive Neurotic, J.F. Suess, 270-275, Sept. 1972.

PATIENT MANAGEMENT

- The Intractable Female Patient, J.H. Houck, 27-31, July 1972.
A Lithium Clinic, D.R. Bey, R.E. Chapman, and K.L. Tornquist, 468-470, Oct. 1972.
Secondary Gain in Long-Term Hemodialysis Patients, D.A. Dansak, 352-355, Sept. 1972.
A Token Reinforcement Ward for Young Psychiatric Patients, M. Hersen, R.M. Eisler, B.S. Smith, and W.S. Agras, 228-233, Aug. 1972.

PEER REVIEW

- A Commentary on "The Pseudo-Regulation of American Psychiatry," S.H. Frazier, 664-668, Dec. 1972.
The Effect of Third-Party Payment on the Practice of Psychotherapy, P. Chodoff, 540-545, Nov. 1972.
The Pseudo-Regulation of American Psychiatry, R.L. Taylor and E.F. Torrey, and discussion by H.J. Tompkins, 658-663, Dec. 1972.

PENTYLENETETRAZOL

- A Controlled Study of the Efficacy of Pentylenetetrazol (Metrazol) with Hard-Core Hospitalized Psychogeriatric Patients, B.A. Stotsky, J.O. Cole, L-M. Lu, and C.M. Sniffin, 387-391, Oct. 1972.

PHARMACOTHERAPY

- Akathisia: A Side Effect To Be Remembered, D.E. Ras-kin, 345-347, Sept. 1972.
Biochemical and Pharmacological Variations in Manic-Depressive Illness, C.D. van der Velde and M.W. Gordon, 337-342, Sept. 1972.
Combined Anticholinergic Agents and Atropine-Like Delirium (Ltrs. to Ed.), D.S. Janowsky, J.M. Davis, M.K. El-Yousef, and H.J. Serkerke, 360-361, Sept. 1972.
Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children, L.M. Greenberg, M.A. Deem, and S. McMahon, 532-539, Nov. 1972.
A Lithium Clinic, D.R. Bey, R.E. Chapman, and K.L. Tornquist, 468-470, Oct. 1972.
Lithium Response in Unipolar Versus Bipolar Depression, F.K. Goodwin, D.L. Murphy, D.L. Dunner, and W.E. Bunney, Jr., 44-47, July 1972.

PHYSICAL DISEASE

- Family Noncommunication: The Search for Kidney Donors, R.G. Simmons and S.D. Klein, 687-692, Dec. 1972.
Goiter in Psychiatric Patients (Ltrs. to Ed.), P. Melia, K. Sinanan, and F. O'Donaghue, 632, Nov. 1972.

- MMPI Profiles of Disability Insurance Claimants, J.W. Shaffer, K. Nussbaum, and J.M. Little, 403-407, Oct. 1972.

- Pediatric Hospitalization as Crisis Intervention, R. Galdston and M.C. Hughes, 721-725, Dec. 1972.
The Psychopathology of Gilles de la Tourette's Syndrome, A.K. Shapiro, E. Shapiro, H. Wayne, and J. Clarkin, 427-434, Oct. 1972.
Secondary Gain in Long-Term Hemodialysis Patients, D.A. Dansak, 352-355, Sept. 1972.

PREGNANCY

- Unwed Motherhood: A Continuing Problem, C.M. Friedman, 85-89, July 1972.
Women Who Seek Therapeutic Abortion: A Comparison with Women Who Complete Their Pregnancies, C.V. Ford, P. Castelnuevo-Tedesco, and K.D. Long, 546-552, Nov. 1972.

PSYCHIATRY ABROAD

- Acupuncture: Ancient Enigma to East and West (Ed. N.), I. Veith, 333-336, Sept. 1972.
A Comparison of Amok and Other Homicide in Laos, J. Westermeyer, and discussion by L.Y. Cheng, 703-709, Dec. 1972.
Establishment of a Psychotherapy Training Department at Tel-Aviv University (Ltrs. to Ed.), E.H. Rosenberg, 634-635, Nov. 1972.
Group Psychotherapy in the Soviet Union, I. Ziferstein, 595-600, Nov. 1972.
The Influence of Psychotic Parents on Their Children's Development, R. Landau, P. Harth, N. Othnay, and C. Sharfheitz, 38-43, July 1972.
The Psychiatrist's Role in Family Planning, I. Siassi, 48-53, July 1972.
Psychiatry in Mainland China: Additional Sources (Ltrs. to Ed.), A.K. Kleinman, and reply of L.M. Koran, 482-484, Oct. 1972.
Psychiatry in Mainland China: Additional Sources (Ltrs. to Ed.), L.J. Ravitz, and reply of L.M. Koran, 483-484, Oct. 1972.
Shamanism Versus Psychiatry in Bali, "Isle of the Gods": Some Modern Implications, S.R. Dean and D. Thong, 59-62, July 1972.

PSYCHOMETRIC TESTS

- The Brief MAST: A Shortened Version of the Michigan Alcoholism Screening Test, A.D. Pokorny, B.A. Miller, and H.B. Kaplan, 342-345, Sept. 1972.
Comparing MMPI Statements and Mental Status Items, D.W. Morgan, W.D. Weitzel, T.E. Guyden, J.A. Robinson, and J.L. Hedlund, 693-697, Dec. 1972.
MMPI Profiles of Disability Insurance Claimants, J.W. Shaffer, K. Nussbaum, and J.M. Little, 403-407, Oct. 1972.

PSYCHOTHERAPY

- Cohesion and Hostility (Ltrs. to Ed.), J.A. Guttmacher, and reply of H.A. Roether and J.J. Petera, 361-363,

- Sept. 1972.
- Counter-Playing: A Group Therapy Technique, J.M. Krainin, 600-601, Nov. 1972.
- Countertransference Resistances in the Supervisory Situation, R.B. Lower, 156-160, Aug. 1972.
- The Effect of Third-Party Payment on the Practice of Psychotherapy, P. Chodoff, 540-545, Nov. 1972.
- The Effectiveness of Group Psychotherapy in a Correctional Institution, C.C. Jew, T.L. Clanon, and A.L. Mattocks, 602-605, Nov. 1972.
- Group Psychotherapy in Perspective (Ed. N.), H. Spotnitz, 606-607, Nov. 1972.
- Group Psychotherapy in the Soviet Union, I. Ziferstein, 595-600, Nov. 1972.
- Heroin Addicts in a Community Mental Health Inpatient Unit, R.S. Poze, 206-210, Aug. 1972.
- The Intractable Female Patient, J.H. Houck, 27-31, July 1972.
- The Jewishness of Jewish Young People: A Symposium, M. Ostow, M.J. Blumenthal, J.A. Arlow, and P.B. Neubauer, 553-561, Nov. 1972.
- Peer Confrontation Groups: What, Why, and Whether, W.W. Van Stone and R. Gilbert, and discussion by J. Steiner, 583-589, Nov. 1972.
- Post-Abortion Group Therapy, G.M. Burnell, W.A. Dworsky, and R.L. Harrington, 220-223, Aug. 1972.
- Psychoanalysis: Out in the Cold? (Ltrs. to Ed.), H.D. Lomas, 768, Dec. 1972.
- Psychotherapy by Counter-Manipulation, J.M. Krainin, 749-751, Dec. 1972.
- The Riddle of Suggestion, N.W. Winkelman, Jr., and S.D. Saul, 477-481, Oct. 1972.
- The Role of Depression in the Treatment of Aggressive Personality Disorders, J.R. Lion, 347-349, Sept. 1972.
- Shamanism Versus Psychiatry in Bali, "Isle of the Gods": Some Modern Implications, S.R. Dean and D. Thong, 59-62, July 1972.
- Short-Term Psychotherapy with the Compulsive Personality and the Obsessive-Compulsive Neurotic, J.F. Suess, 270-275, Sept. 1972.
- Social and Clinical Issues in Geriatric Psychiatry, B.A. Stotsky, 117-126, Aug. 1972.
- Symbiosis in Adulthood, D.A. Shapiro, 289-292, Sept. 1972.
- Training of Mental Health Professionals Through the Use of the "Bug in the Ear," W.H. Boylston and J.M. Tuma, 92-95, July 1972.
- Why Men Seek Psychotherapy: I. Results of a Survey of College Graduates, G.E. Vaillant, 645-651, Dec. 1972.

RACISM

- Community Control of the Community Mental Health Center: I. Introduction, W.M. Bolman, 173-180, Aug. 1972.
- Community Control of the Community Mental Health Center: II. Case Examples, W.M. Bolman, 181-186, Aug. 1972.
- A Decade of Change in Drawings by Black Children, J.E. Fish and C.J. Larr, and discussion by J.F. McDermott, Jr., 421-426, Oct. 1972.
- Reaching Black Professionals (Ltrs. to Ed.), L.H. Lipsius, and reply of V.W. Bernard, 631, Nov. 1972.
- Subcontracts for Community Development and Service, H.M. Freed, 568-573, Nov. 1972.

RELIGION

- Ancient Descriptions of Organic Brain Syndrome: The "Kordiakos" of the *Talmud*, L.D. Hankoff, 233-236, Aug. 1972.
- Drug Use: Religion and Secularization (Ltrs. to Ed.), S. Cohen, 97, July 1972.
- The Jewishness of Jewish Young People: A Symposium, M. Ostow, M.J. Blumenthal, J.A. Arlow, and P.B. Neubauer, 553-561, Nov. 1972.
- Peyote Use: A Case Report (Ltrs. to Ed.), M.L. Wadsworth, and reply of R.L. Bergman, 96-97, July 1972.
- Request for Information (Ltrs. to Ed.), C.A. Frazier, 361, Sept. 1972.
- Shamanism Versus Psychiatry in Bali, "Isle of the Gods": Some Modern Implications, S.R. Dean and D. Thong, 59-62, July 1972.

SCHIZOPHRENIA

- Schizophrenia and Affective Psychosis: Additional Comments (Ltrs. to Ed.), P.C.S. Hoaken, and reply of E. Ziskind, E. Somerfeld, and R. Jens, 632-633, Nov. 1972.
- Symbiosis in Adulthood, D.A. Shapiro, 289-292, Sept. 1972.

SELF-MUTILATION

- A Third Case of Self-Enucleation (Ltrs. to Ed.), J. Westermeyer and A. Serposs, 484, Oct. 1972.

SEXUAL DEVIANCE

- Identical Twins: Concordance for Homosexuality? (Ltrs. to Ed.), C.C. Taylor, 486-487, Oct. 1972.

SEXUALITY

- Post-Abortion Group Therapy, G.M. Burnell, W.A. Dworsky, and R.L. Harrington, 220-223, Aug. 1972.
- Sex, Age, and the Diagnosis of Hysteria (Briquet's Syndrome), S.B. Guze, R.A. Woodruff, Jr., and P.J. Clayton, 745-748, Dec. 1972.
- Sexual Behavior: Significant Changes (Ltrs. to Ed.), H.I. Lief, 768-769, Dec. 1972.
- Unwed Motherhood: A Continuing Problem, C.M. Friedman, 85-89, July 1972.

SLEEP STUDIES

- Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion, R. Watson, E. Hartmann, and J.J. Schildkraut, 263-269, Sept. 1972.
- Tardive Dyskinesia and the Rabbit Syndrome During Wakefulness and Sleep (Ltrs. to Ed.), K. Jus, A. Ville-neuve, and A. Jus, 765, Dec. 1972.

SOCIAL PSYCHIATRY

- Abortions: Regaining Objectivity or Rationalization?

- (Ltrs. to Ed.), E.F. Kal, and reply of W.F. Char, 484-485, Oct. 1972.
- Automated History Taking in Child Psychiatry, R.D. Coddington and T.L. King, 276-282, Sept. 1972.
- Caring for the Terminally Ill: A Hospice (Ltrs. to Ed.), M.D. Kerstein, 237-238, Aug. 1972.
- Character and Behavior Disorder: A Way to Discharge Men from the Service (Ltrs. to Ed.), R.B. Kennedy, 765-766, Dec. 1972.
- Child Custody Laws: Their Psychiatric Implications, E.P. Benedek, 326-328, Sept. 1972.
- A Commentary on "The Pseudo-Regulation of American Psychiatry," S.H. Frazier, 664-668, Dec. 1972.
- Community Control of the Community Mental Health Center: I. Introduction, W.M. Bolman, 173-180, Aug. 1972.
- Community Control of the Community Mental Health Center: II. Case Examples, W.M. Bolman, 181-186, Aug. 1972.
- Community Mental Health Centers: Coming to Grips with Big Ideas (Ed. N.), M. Martin, 211-213, Aug. 1972.
- Community Psychiatry and Emergency Service, D.A. Schwartz, A.T. Weiss, and J.M. Miner, 710-715, Dec. 1972.
- A Comparison of Amok and Other Homicide in Laos, J. Westermeyer, and discussion by L.Y. Cheng, 703-709, Dec. 1972.
- Comprehensive Health Planning (Ltrs. to Ed.), R.L. Williams, 237, Aug. 1972.
- Crisis Intervention (Ed. N.), D.G. Langsley, 734-736, Dec. 1972.
- Crisis Intervention and Prevention of Psychiatric Disability: A Follow-Up Study, J.B. Decker and J.M. Stubblebine, 725-729, Dec. 1972.
- Courts, State Hospitals, and the Right to Treatment, J. Robitscher, 298-304, Sept. 1972.
- Death, Dying, and Denial in the Aged, L.R. Kimsey, J.L. Roberts, and D.L. Logan, 161-166, Aug. 1972.
- A Decade of Change in Drawings by Black Children, J.E. Fish and C.J. Larr, and discussion by J.F. McDermott, Jr., 421-426, Oct. 1972.
- Delivery of Services to Lower Socioeconomic Groups by a Suburban Community Mental Health Center, W.T. Hart and L. Bassett, 191-196, Aug. 1972.
- Drug Abuse in Viet Nam, J. Char, 463-465, Oct. 1972.
- Drug Use: Religion and Secularization (Ltrs. to Ed.), S. Cohen, 97, July 1972.
- The Foster Community: A Partnership in Psychiatric Rehabilitation, A. Keskiner, M.J. Zalcman, E.H. Rupert, and G.A. Ulett, 283-288, Sept. 1972.
- Goals and Functions of the Community Mental Health Center, M. Wachspress, 187-190, Aug. 1972.
- Help for Adopting Parents (Ltrs. to Ed.), L. Tec, 99-100, July 1972.
- Heroin Addicts in a Community Mental Health Inpatient Unit, R.S. Poze, 206-210, Aug. 1972.
- Homicidal Acts of War (Ltrs. to Ed.), G.M. Bates, Jr., and reply of E. Tanay, 766-767, Dec. 1972.
- Hotlines and Youth Culture Values, P. Torop and K. Torop, 730-733, Dec. 1972.
- The Jewishness of Jewish Young People: A Symposium, M. Ostow, M.J. Blumenthal, J.A. Arlow, and P.B. Neubauer, 553-561, Nov. 1972.
- Lobotomies: An Alert (Ltrs. to Ed.), P.R. Breggin, 97-98, July 1972.
- Methadone Maintenance: Expanding the Concept of Service (Ed. N.), M.E. Perkins, 461-462, Oct. 1972.
- The Mini-Boards: Their Place in Psychiatric Training (Ltrs. to Ed.), J.A. Baxter, and reply of D.E. Raskin, 635-636, Nov. 1972.
- The New Face of Legal Psychiatry, J. Robitscher, 315-321, Sept. 1972.
- The 1971 Amendment of the Illinois Statute on Confidentiality: A New Development in Privilege Law, J.S. Beigler, 311-315, Sept. 1972.
- The Overturning of Another Landmark (Ed. N.), N.L. Chayet, 331-333, Sept. 1972.
- Partial Hospitalization Within an Urban Slum, P. Ruiz and G. Saiger, and discussion by S.R. Fried, 89-92, July 1972.
- Peyote Use: A Case Report (Ltrs. to Ed.), M.L. Wadsworth, and reply of R.L. Bergman, 96-97, July 1972.
- Physician Use of Marijuana, Alcohol, and Tobacco, M.R. Lipp and S.G. Benson, 612-616, Nov. 1972.
- The Psychiatrist's Role in Family Planning, I. Siassi, 48-53, July 1972.
- Psychiatry and the Criminal Law System, J.M. Suarez, 293-297, Sept. 1972.
- Psychiatry and the Legal Rights of Patients. L. Tancred, and D. Clark, 328-330, Sept. 1972.
- Psychiatry as a Medical Specialty (Ltrs. to Ed.), A.J. Gelenberg, 633-634, Nov. 1972.
- The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), H.I. Posin, and reply of Z.M. Lebensohn, 358, 360, Sept. 1972.
- The Quality of Life as Opposed to the Right to Life (Ltrs. to Ed.), W.G. Smith, and reply of Z.M. Lebensohn, 358-360, Sept. 1972.
- Rehospitalization Versus Family Crisis Intervention, D. Rubinstein, 715-720, Dec. 1972.
- Response to the Presidential Address, P.C. Talkington, 10-11, July 1972.
- The Riddle of Suggestion, N.W. Winkelman, Jr., and S.D. Saul, 477-481, Oct. 1972.
- Sexual Behavior: Significant Changes (Ltrs. to Ed.), H.I. Lief, 768-769, Dec. 1972.
- Social and Clinical Issues in Geriatric Psychiatry, B.A. Stotsky, 117-126, Aug. 1972.
- A Systems Approach to Alcoholism Programming, H.D. Holder and N.E. Stratas, 32-37, July 1972.
- Those Who Kill Without Thinking (Ltrs. to Ed.), R.L. Goldstein, and reply of E. Tanay, 766-767, Dec. 1972.
- Unwed Motherhood: A Continuing Problem, C.M. Friedman, 85-89, July 1972.
- Why Men Seek Psychotherapy: I. Results of a Survey of College Graduates, G.E. Vaillant, 645-651, Dec. 1972.

SUGGESTION

- The Riddle of Suggestion, N.W. Winkelman, Jr., and S.D. Saul, 477-481, Oct. 1972.

SUICIDE

- Aberrant Response to Diazepam: A New Syndrome. R.C.W. Hall and J.R. Joffe, 738-742, Dec. 1972.
- Aggression—Quantitative Data (Ltrs. to Ed.), D. Lester, 238, Aug. 1972.
- A Third Case of Self-Enucleation (Ltrs. to Ed.), J. Westermeyer and A. Serposs, 484, Oct. 1972.

SYMBIOTIC PSYCHOSIS

Symbiosis in Adulthood, D.A. Shapiro, 289-292, Sept. 1972.

SYSTEMS THEORY

Administrative Psychiatry, M. Greenblatt, 373-386, Oct. 1972.

Psychiatry and the Criminal Law System, J.M. Suarez, 293-297, Sept. 1972.

A Systems Approach to Alcoholism Programming, H.D. Holder and N.E. Stratas, 32-37, July 1972.

TARDIVE DYSKINESIA

Prevention and Management of Tardive Dyskinesia, G.E. Crane, 466-467, Oct. 1972.

Tardive Dyskinesia and the Rabbit Syndrome During Wakefulness and Sleep (Ltrs. to Ed.), K. Jus, A. Villeneuve, and A. Jus, 765, Dec. 1972.

TRANSCULTURAL PSYCHIATRY

Aggression—Quantitative Data (Ltrs. to Ed.), D. Lester, 238, Aug. 1972.

A Comparison of Amok and Other Homicide in Laos, J.

Westermeyer, and discussion by L.Y. Cheng, 703-709, Dec. 1972.

The Jewishness of Jewish Young People: A Symposium, M. Ostow, M.J. Blumenthal, J.A. Arlow, and P.B. Neubauer, 553-561, Nov. 1972.

Peyote Use: A Case Report (Ltrs. to Ed.), M.L. Wadsworth, and reply of R.L. Bergman, 96-97, July 1972.

The Psychiatrist's Role in Family Planning, I. Siassi, 48-53, July 1972.

Shamanism Versus Psychiatry in Bali, "Isle of the Gods": Some Modern Implications, S.R. Dean and D. Thong, 59-62, July 1972.

TWIN STUDIES

Identical Twins: Concordance for Homosexuality? (Ltrs. to Ed.), C.C. Taylor, 486-487, Oct. 1972.

TWO-WAY TELEVISION

Two-Way Television: Helping the Medical Center Reach Out, C.L. Wittson and R. Benshoter, 624-627, Nov. 1972.

WATER INTOXICATION

Psychogenic Water Intoxication: A Case Report, M.W. Devereaux and R.A. McCormick, 628-630, Nov. 1972.

THE AMERICAN JOURNAL OF PSYCHIATRY



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July 1972

SPECIAL SECTION

PRESIDENTIAL PAPERS: 1972

- The Presidential Address: There Are
Decisions To Be Made *Ewald W. Busse*
Response to the Presidential Address
Perry C. Talkington
Ewald William Busse, M.D., One
Hundredth President, 1971-1972
Waller E. Barton

- The Puetlo Incident: Psychological
Reactions to the Stresses of
Imprisonment and Repatriation
*Raymond C. Spaulding and
Charles V. Ford*
The Intractable Female Patient
John H. Houck
A Systems Approach to Alcoholism
Programming *Harold D. Holder
and Nicholas E. Stratas*
The Influence of Psychotic Parents on
Their Children's Development *Rita
Landau, Paula Harth, Nava Othnay, and
Cila Skarfherzt*
Lithium Response in Unipolar Versus
Bipolar Depression *Frederick K.
Goodwin, Dennis L. Murphy, David L.
Dunner, and William E. Bunney, Jr.*
The Psychiatrist's Role in Family
Planning *Iradj Siassi*
A Systematic Approach for Oral Board
Examinations in Psychiatry *Alan L.
Morgenstern*
Shamanism Versus Psychiatry in Bali,
"Isle of the Gods": Some Modern

Implications *Stanley R. Dean and
Denny Thong*

- 1 Experiences in Establishing School
Consultation *H. Spencer Bloch* 63

10

BRIEF COMMUNICATIONS

- 12 Homicides and the Lunar Cycle: Toward
a Theory of Lunar Influence on Human
Emotional Disturbance *Arnold L.
Lieber and Carolyn R. Sherin* 69
17 The Use of Doxepin in the Treatment of
Symptoms of Anxiety Neurosis and
Accompanying Depression: A
Collaborative Controlled Study *Harold
L. Goldberg and Richard J. Finnerty* 74
27 Comparison of Injectable Haloperidol and
Chlorpromazine *Robert M. Ritter,
David E. Davidson, and Thomas A.
Robinson* 78
32 An Attempt to Study Time Utilization in
a Mental Health Program *Colin F.
Lipscomb* 82
38 Unwed Motherhood: A Continuing
Problem *Cornelia Morrison Friedman* 85
44 Partial Hospitalization Within an Urban
Slum *Pedro Ruiz and George Saiger* 89
Training of Mental Health Professionals
Through the Use of the "Bug in the
Ear" *William H. Boylston and June
M. Tuma* 92
48

- 54 LETTERS TO THE EDITOR 96

- BOOK REVIEWS 101

- 59 OFFICIAL ACTIONS
Highlights of the 125th Annual Meeting 113

August 1972

- Social and Clinical Issues in Geriatric
Psychiatry *Bernard A. Stolsky* 117
Criteria for the Diagnosis of Alcoholism
*The Criteria Committee, National Council
on Alcoholism* 127
Psychiatric Liaison with Neurology and
Neurosurgery *Z.J. Lipowski* 136
Amine Precursors, Amines, and False
Neurotransmitters in Depressed
Patients *Dennis L. Murphy* 141
Proposed Classification of Childhood
Depression *Leon Cytryn and Donald H.
McKnew, Jr.* 149
Countertransference Resistances in the
Supervisory Situation *Richard B. Lower* 156
Death, Dying, and Denial in the Aged
*Larry R. Kimsey, Jean L. Roberts,
and Daniel L. Logan* 161
Inmate Responses to Lengthy Death Row
Confinement *Johnnie L. Gallemore, Jr.,
and James H. Panton* 167
181
SPECIAL SECTION
COMMUNITY MENTAL HEALTH CENTERS:
EMERGING PATTERNS
149 Community Control of the Community
Mental Health Center: I. Introduction
William M. Bolman 173
156 Community Control of the Community
Mental Health Center: II. Case 181

Examples	<i>William M. Bolman</i>
Goals and Functions of the Community Mental Health Center	<i>Morton Wachspress</i>
Delivery of Services to Lower Socioeconomic Groups by a Suburban Community Mental Health Center	<i>William T. Hart and Louise Bassett</i>
Continuity of Care: An Approach to Measurement	<i>Rosalyn D. Bass and Charles Windle</i>
The Effect on State Hospitalization of a Community Mental Health/Mental Retardation Center	<i>Jack A. Wolford, John Hitchcock, David L. Ellison, Anne C. Sonis, and Fred Smith</i>
Heroin Addicts in a Community Mental Health Inpatient Unit	<i>Ronald Serwer Poze</i>

EDITOR'S NOTEBOOK

Community Mental Health Centers: Coming to Grips with Big Ideas	<i>Morgan Martin</i>
Alcoholism Criteria: An Important Step	

Morris E. Chafetz

187	BRIEF COMMUNICATIONS	
	Determination of the Obsessional Personality	<i>Peter Hays</i> 217
191	Post-Abortion Group Therapy	<i>George M. Burnell, William A. Dworsky, and Robert L. Harrington</i> 220
196	Hysteria (Briquet's Syndrome) in a Psychiatric Hospital: The Significance of Secondary Depression	<i>Richard C. Bibb and Samuel B. Guze</i> 224
202	A Token Reinforcement Ward for Young Psychiatric Patients	<i>Michel Hersen, Richard M. Eisler, Buren S. Smith, and W. Stewart Agras</i> 228
206	Ancient Descriptions of Organic Brain Syndrome: The "Kordiakos" of the Talmud	<i>L.D. Hankoff</i> 233

LETTERS TO THE EDITOR 237

BOOK REVIEWS 241

OFFICIAL ACTIONS

214	The American Board of Psychiatry and Neurology	255
-----	--	-----

September 1972

The Lame Princess: A Study of the Remission of Psychiatric Symptoms Without Treatment	<i>Morton Beiser</i>
Amphetamine Withdrawal: Affective State, Sleep Patterns, and MHPG Excretion	<i>Robert Watson, Ernest Hartmann, and Joseph J. Schildkraut</i>
Short-Term Psychotherapy with the Compulsive Personality and the Obsessive-Compulsive Neurotic	<i>James F. Suess</i>
Automated History Taking in Child Psychiatry	<i>R. Dean Coddington and Thomas L. King</i>
The Foster Community: A Partnership in Psychiatric Rehabilitation	<i>Ali Keskiner, Marilyn J. Zalzman, Emily H. Ruppert, and George A. Ulell</i>
Symbiosis in Adulthood	<i>David A. Shapiro</i>

SPECIAL SECTION

PSYCHIATRY AND LAW

Psychiatry and the Criminal Law System	<i>John M. Suarez</i>
Courts, State Hospitals, and the Right to Treatment	<i>Jonas Robitscher</i>
The Community Adjustment and Criminal Activity of the Baxstrom Patients:	

257	1966-1970	<i>Henry J. Steadman and Gary Keveles</i>
263	The 1971 Amendment of the Illinois Statute on Confidentiality: A New Development in Privilege Law	<i>Jerome S. Beigler</i> 311
270	The New Face of Legal Psychiatry	<i>Jonas Robitscher</i> 315
	A Psychiatric Clerkship for Law Students	<i>John Clancy, Gene Brodland, and Samuel Fehr</i> 322
276	Child Custody Laws: Their Psychiatric Implications	<i>Elissa P. Benedek</i> 326
283	Psychiatry and the Legal Rights of Patients	<i>Laurence Tancredi and Diana Clark</i> 328

EDITOR'S NOTEBOOK

289	The Overturning of Another Landmark	<i>Neil L. Chayet</i> 331
	Acupuncture: Ancient Enigma to East and West	<i>Ilza Veith</i> 333

BRIEF COMMUNICATIONS

293	Biochemical and Pharmacological Variations in Manic-Depressive Illness	<i>Christiaan D. van der Velde and Malcolm W. Gordon</i> 337
304	The Brief MAST: A Shortened Version of	342

the Michigan Alcoholism Screening Test <i>Alex D. Pokorny, Byron A. Miller, and Howard B. Kaplan</i>		Hemodialysis Patients <i>Daniel A. Dansak</i>	
Akathisia: A Side Effect To Be Remembered <i>David E. Raskin</i>	345	IN MEMORIAM	
The Role of Depression in the Treatment of Aggressive Personality Disorders <i>John R. Lion</i>	347	Walter Freeman, 1895-1972 <i>Zigmond M. Lebensohn</i>	356
The Firstborn Phenomenon Among Psychiatric Residents <i>Sheldon H. Kardener and Marielle Fuller</i>	350	LETTERS TO THE EDITOR	358
Secondary Gain in Long-Term	352	BOOK REVIEWS	364
		OFFICIAL ACTIONS	
		Committee on Certification in Administrative Psychiatry	372

October 1972

Administrative Psychiatry <i>Millon Greenblatt</i>	373	Programs <i>Marvin E. Perkins and Alex Richman</i>	
A Controlled Study of the Efficacy of Pentylentetrazol (Metrazol) with Hard-Core Hospitalized Psychogeriatric Patients <i>Bernard A. Stotsky, Jonathan O. Cole, Leigh-Min Lu, and Celia M. Sniffin</i>	387	Methadone: Some Aspects of Its Legal and Illegal Use <i>Robert S. Weppner, Richard C. Stephens, and Harold T. Conrad</i>	451
Amnesty's Impact Upon Drug Use: A Pre/Post Study <i>John F. Greden and Donald W. Morgan</i>	392	Personality Correlates of Success in a Methadone Maintenance Program <i>David G. Levine, Donald B. Levin, Ira H. Sloan, and John N. Chappel</i>	456
Some Psychiatric Sequelae to Crib Death <i>Werner I. Halpern</i>	398	EDITOR'S NOTEBOOK	
MMPI Profiles of Disability Insurance Claimants <i>John W. Shaffer, Kurt Nussbaum, and John M. Little</i>	403	Methadone Maintenance: Expanding the Concept of Service <i>Marvin E. Perkins</i>	461
The Relevance of History for the Community Mental Health Approach to Children <i>George Mora</i>	408	BRIEF COMMUNICATIONS	
Marijuana and Other Drug Use by Graduate and Professional Students <i>Beatrice A. Rouse and John A. Ewing</i>	415	Drug Abuse in Viet Nam <i>Jerome Char</i>	463
A Decade of Change in Drawings by Black Children <i>Jeanne E. Fish and Charlotte J. Larr</i>	421	Prevention and Management of Tardive Dyskinesia <i>George E. Crane</i>	466
The Psychopathology of Gilles de la Tourette's Syndrome <i>Arthur K. Shapiro, Elaine Shapiro, Henriette Wayne, and John Clarkin</i>	427	A Lithium Clinic <i>D.R. Bey, R.E. Chapman, and K.L. Tornquist</i>	468
		High Expectations of Long-Term Ex-State Hospital Patients <i>H. Richard Lamb and Victor Goertzel</i>	471
		Marijuana and Mutism <i>David B. Marcolle</i>	475
		The Riddle of Suggestion <i>N. William Winkelman, Jr., and Steven D. Saul</i>	477
		LETTERS TO THE EDITOR	482
SPECIAL SECTION		BOOK REVIEWS	488
METHADONE MAINTENANCE		OFFICIAL ACTIONS	
Methadone Maintenance: Myth and Reality <i>Charles L. Bowden and James F. Maddux</i>	435	Report of the Secretary	502
Critique of Success with Methadone Maintenance <i>James F. Maddux and Charles L. Bowden</i>	440	Report of the Treasurer	508
Prevalence of Participation in Methadone	447	Report of the Medical Director	511
		Report of the Speaker	512
		1972 Annual Report of the American Board of Psychiatry and Neurology	514
		Proposed Amendments to the Constitution and By-Laws	517

November 1972

The Phases of Adult Life: A Study in Developmental Psychology <i>Roger L. Gould</i>	521	in a Group <i>John S. Tamerin</i>	
Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children <i>L.M. Greenberg, M.A. Deem, and S. McMahon</i>	532	Group Psychotherapy in the Soviet Union <i>Isidore Ziferstein</i>	595
The Effect of Third-Party Payment on the Practice of Psychotherapy <i>Paul Chodoff</i>	540	Counter-Playing: A Group Therapy Technique <i>James M. Krainin</i>	600
Women Who Seek Abortion: A Comparison with Women Who Complete Their Pregnancies <i>Charles V. Ford, Pietro Castelnovo-Tedesco, and Kahlila D. Long</i>	546	The Effectiveness of Group Psychotherapy in a Correctional Institution <i>Charles C. Jew, T.L. Clanon, and Arthur L. Matlocks</i>	602
The Jewishness of Jewish Young People: A Symposium <i>Mortimer Ostow, Mortimer J. Blumenthal, Jacob A. Arlow, and Peter B. Neubauer</i>	553		
On the Bicentenary of the Birth of Esquirol (1772-1840), the First Complete Psychiatrist <i>George Mora</i>	562	EDITOR'S NOTEBOOK	
Subcontracts for Community Development and Service <i>Harvey M. Freed</i>	568	Group Psychotherapy in Perspective <i>Hyman Spolniz</i>	606
Adolescents in Crisis: Evaluation of a Questionnaire <i>Alvin Yusin, Ruth Sinay, and Kazuo Nihira</i>	574	BRIEF COMMUNICATIONS	
Continuing Education for Community Psychiatry <i>Louis F. Rittelmeyer, Jr., Robert G. Kvarnes, and Irving Schneider</i>	578	Adolescent Maladjustment or Affective Disorder? <i>Johnnie L. Gallemore, Jr., and William P. Wilson</i>	608
		Physician Use of Marijuana, Alcohol, and Tobacco <i>Martin R. Lipp and Samuel G. Benson</i>	612
		The Attitudes of Patients and Their Trainee Therapists Toward Participation in Psychiatric Board Examinations <i>Herbert H. Eveloff and Charles P. McCreary</i>	616
		Acute Brain Syndrome Associated with Lithium Therapy <i>Peter L. Agulnik, Alberto DiMascio, and Patricia Moore</i>	621
		Two-Way Television: Helping the Medical Center Reach Out <i>Cecil L. Willson and Reba Benschoter</i>	624
		Psychogenic Water Intoxication: A Case Report <i>Michael W. Devereaux and Ruth A. McCormick</i>	628
SPECIAL SECTION		LETTERS TO THE EDITORS	631
GROUP THERAPY		BOOK REVIEWS	637
Peer Confrontation Groups: What, Why, and Whether <i>William W. Van Stone and Robert Gilbert</i>	583		
The Psychodynamics of Quitting Smoking	589		

December 1972

Why Men Seek Psychotherapy: I. Results of a Survey of College Graduates <i>George E. Vaillant</i>	645	<i>H. Augustus Taylor, and Peter E. Nathan</i>	
1972 Anniversaries <i>George Mora</i>	652	Depression During Mania: Clinical Observations and Theoretical Implications <i>Joel Kotin and Frederick K. Goodwin</i>	679
The Pseudo-Regulation of American Psychiatry <i>Robert L. Taylor and E. Fuller Torrey</i>	658	Family Noncommunication: The Search for Kidney Donors <i>Roberta G. Simmons and Susan D. Klein</i>	687
A Commentary on "The Pseudo-Regulation of American Psychiatry" <i>Shervert H. Frazier</i>	664	Comparing MMPI Statements and Mental Status Items <i>Donald W. Morgan, William D. Weitzel, Thomas E. Guyden, James A. Robinson, and James L. Hedlund</i>	693
Group Drinking During Stress: Effects on Drinking Behavior, Affect, and Psychopathology <i>Lawrence R. Allman,</i>	669	Change of Command in Combat: A Locus	698

of Stress *Douglas R. Bey, Jr.*
 A Comparison of Amok and Other
 Homicide in Laos *Joseph Westermeyer*

SPECIAL SECTION

CRISIS INTERVENTION

Community Psychiatry and Emergency
 Service *Donald A. Schwartz, Audrey T.*
Weiss, and James M. Miner

Rehospitalization Versus Family Crisis
 Intervention *David Rubinstein*

Pediatric Hospitalization as Crisis
 Intervention *Richard Galdston and*
Michael C. Hughes

Crisis Intervention and Prevention
 of Psychiatric Disability: A Follow-Up
 Study *J. Barry Decker and J.M.*
Stubblebine

Hotlines and Youth Culture Values
Paul Torop and Karen Torop

EDITOR'S NOTEBOOK

Crisis Intervention *Donald G. Langsley*
 Changes in the Offing *F.J.B.*

BRIEF COMMUNICATIONS

Aberrant Response to Diazepam: A New

Syndrome *Richard C.W. Hall and*
Joy R. Joffe

The Importance of Psychiatrists' Telling
 Patients the Truth *William S. Appleton*

Sex, Age, and the Diagnosis of
 Hysteria (Briquet's Syndrome)

Samuel B. Guze, Robert A. Woodruff, Jr.,
and Paula J. Clayton

Psychotherapy by Counter-Manipulation
James M. Krainin

Drug Flashbacks: Reported Frequency
 in a Military Population *M. Duncan*

Stanton and Alexander Bardoni

The Psychology of Hallucinogenic Drug
 Discontinuers *Carl Salzman, Jonathan*

Lieff, Gerald E. Kochansky, and Richard
I. Shader

IN MEMORIAM

Thomas J. Heldt, 1883-1972 *John M.*
Dorsey

Austin M. Davies, 1900-1972 *F.J.B.*

LETTERS TO THE EDITOR

BOOK REVIEWS

ANNUAL INDEX

Author Index

Subject Index

703

710

715

721

725

730

734

736

738

742

745

749

751

755

762

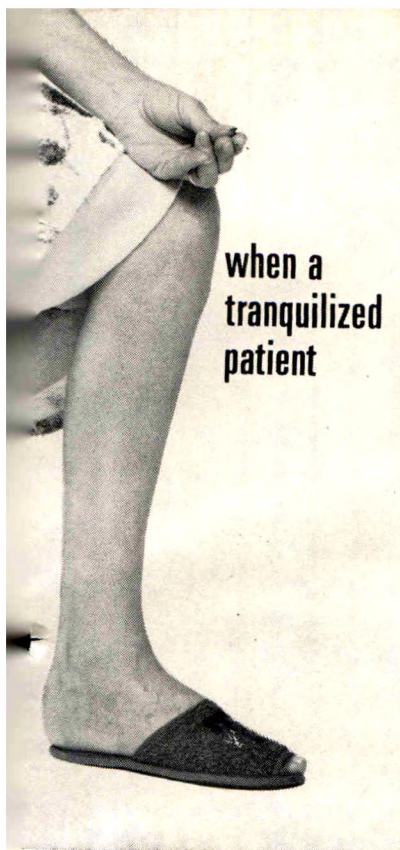
763

765

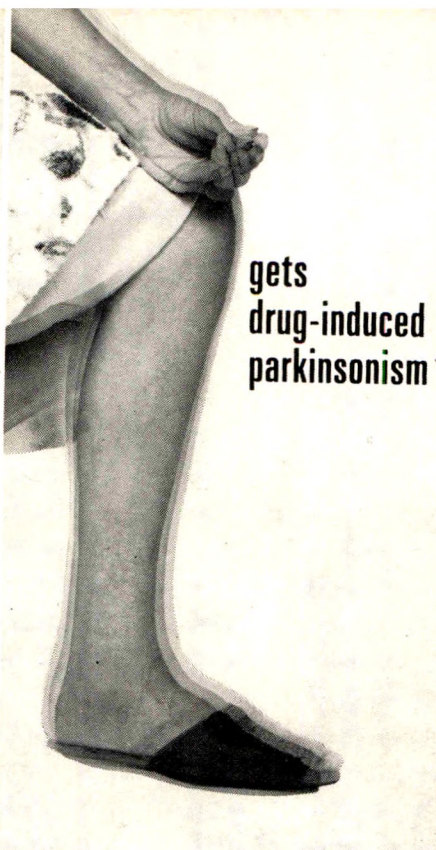
770

780

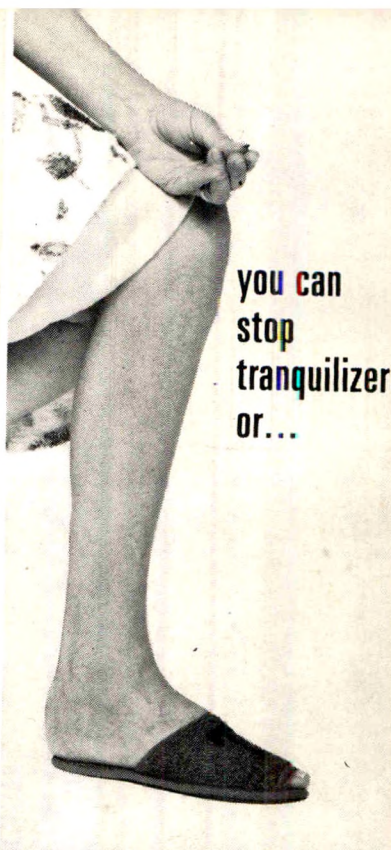
786



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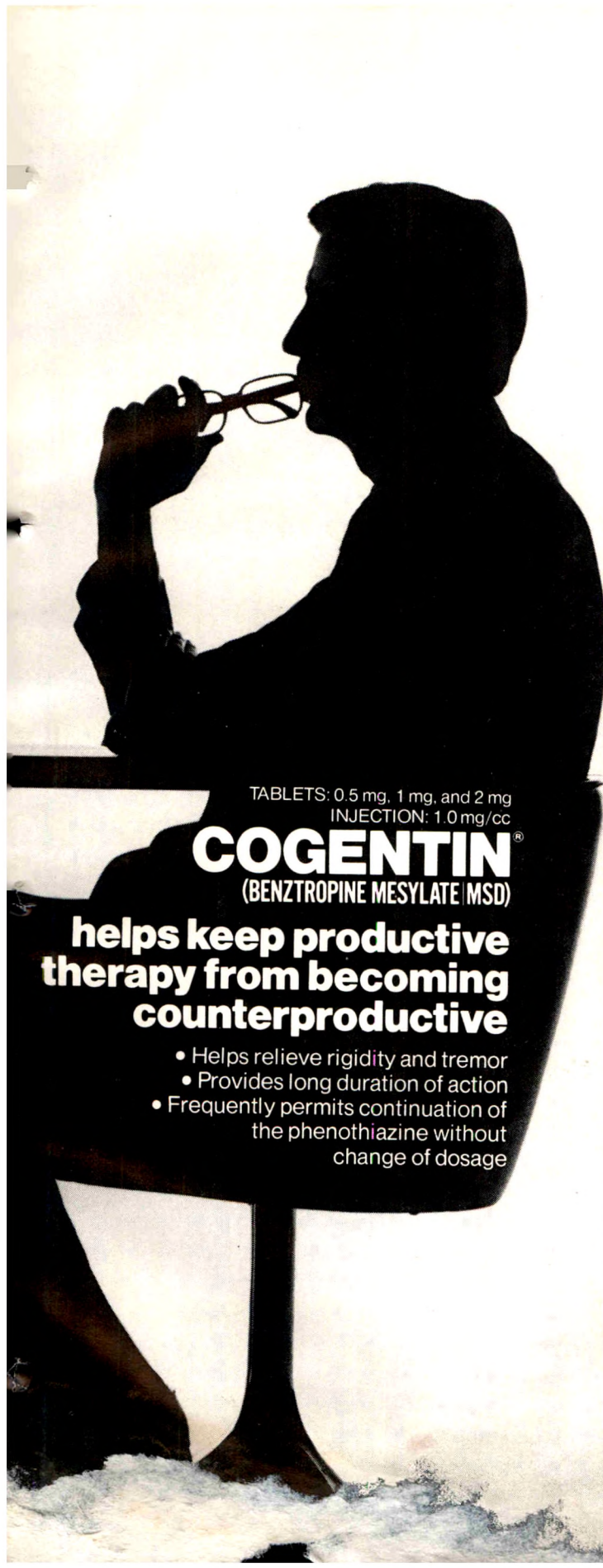
1. Lapolla, A. and Nash, L. R.: *Current Therapeutic Research* 7:536 (Sept.) 1965. 2. Sheppard, C. and Merlis, S.: *American Journal of Psychiatry* 123:886 (Jan.) 1967.

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Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia or hypotension and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Masking action on possible development of permanent extrapyramidal symptoms with prolonged phenothiazine therapy has not been investigated. Patients with a poor mental outlook are usually poor candidates for therapy.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma. Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. In drug-induced parkinsonism, closely observe patients for severe reactions, and temporarily discontinue COGENTIN (Bentropine Mesylate, MSD) if they appear; do not extend therapy longer than necessary to counteract the extrapyramidal disorders; although the psychotropic drug frequently can be continued without change of dosage, a decrease might be indicated.

Adverse Reactions: Adverse reactions may be anticholinergic and/or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

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For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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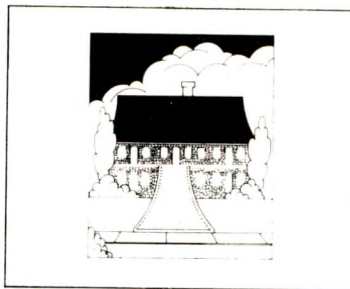
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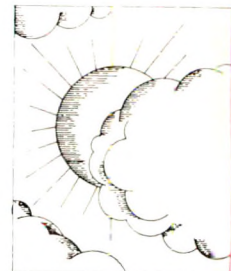
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ADVERTISERS INDEX

CADEMIC PRESS	1
CORRECTIVE THERAPY AND JOURNAL OF SOCIAL THERAPY	13
DEVEREUX FOUNDATION	C4
DOW PHARMACEUTICALS Quide	190-192
KNOLL PHARMACEUTICAL Akineton	185
LA HACIENDA	189
LEDERLE Artane	20
MERCK SHARP & DOHME Cogentin	186, 187
Elavil	14, 15
Triavil	202-204
O'NEAL, JONES & FELDMAN, INC. Antilirium	7
OXFORD UNIVERSITY PRESS	6
REUBEN REITER, ScD. INC. Electrostimulators	CIII
ROCHE LABORATORIES Librium	16, 17
Valium	9-12
SANDOZ Mellaril	18, 19
Serentil	194-196
SANITARIUMS AND PRIVATE HOSPITALS	193, 197
SMITH KLINE AND FRENCH LABORATORIES Stelazine/Thorazine	C2
WYETH LABORATORIES Serex	198-200

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